STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085052	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from August 27, 2018 through September 6, 2018. The facility census the first day of the survey was 106 (one hundred six). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 27, 2018 through September 6, 2018. The deficiencies contained in this report were based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 106. The survey sample totaled forty five (45) plus five (5) additional complaint / FRI residents. Abbreviations/Definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - Occupational Therapist; PT - Physical Therapy / Physical Therapist; RD - Registered Dietician; RN - Registered Nurse; SW - Social Worker; SDS - Supply Distribution Staff;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 SLP (Speech Language Pathologist) - Speech Therapist; UM - Unit Manager; ADLs (Activities of Daily Living) tasks such as eating, bathing, toileting and dressing; ADL Self-Performance - Extensive Assistance: resident involved in activity, staff provide weight-bearing support; - Limited Assistance: resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Supervision: oversight, encouragement or cueing; - Total Dependence - full staff performance every time activity performed; Afib (Atrial Fibrillation) - irregular heart rhythm that increases risk for blood clots; Albumin - protein made by the liver; Analgesic - pain medication; Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness; Antidepressant - medication to treat depression; Antirollbacks - device added to wheelchair to prevent chair from rolling backward if brakes not activated; anxiety-persistent worry about everyday situations; Aseptic - technique that is absence of any germs; Asthma - a disease causing difficulty breathing; antipsychotic-class of medications used to treat mental disorders; Ativan - medication for anxiety; Bed Mobility - moving, turning, sitting up in bed; Benadryl: allergy medication that can cause sleepiness; BIMS - (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact	F 000		

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F 000	Continued From page 2 08-12: Moderately impaired 00-07: Severe impairment Bladderscan - machine to measure amount of urine in the bladder; Blood Pressure (BP) - measure of the force of blood against the walls of a blood vessel; Braden Scale - tool used to assess a patent's risk of developing a pressure ulcer (the lower the score the higher the risk for developing pressure ulcer); BUN and Creatinine - blood tests that look at kidney function; BMI- body mass index; cc (Cubic Centimeter) - unit of liquid volume, 5 cc equals 1 teaspoon; CDC - Centers for Disease Control and Prevention; cm (Centimeter) - a metric measurement of length; 1 centimeter = 0.39 inches; c/o - complaint of; Cognition - mental processes, thinking, memory; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; C&S (culture and sensitivity) - test to determine the type of organism and which antibiotic is the best treatment; Delusion - a belief held with strong conviction despite evidence to the contrary; Demarcation - border between healthy and unhealthy skin; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dermoplast spray - pain and itch relieving spray; Ecchymosis - skin color change from damage to blood vessels; Ecoli - bacteria found in the intestines of humans; Edema - swelling; 1+ = can press down 2 mm or less, slight	F 000		

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F 000	Continued From page 3	F 000		

pitting (pit), indentation disappears rapidly;
2+ = can press 2-4 mm, somewhat deeper pit, indentation disappears in 10-25 seconds;
3+ = can press down 4-6 mm, pit noticeably deep and may last more than a minute;
4+ = can press down 6-8 mm, pit very deep and lasts over 2 minutes;
e.g. - for example;
eMAR - Electronic Medication Administration Record;
EMR - Electronic Medical Record;
ER - Emergency Room;
etc.-and so forth;
Etiology - cause;
Foley catheter - tube held in the bladder by a small balloon to drain urine;
FRI - Facility Reported Incident:
Gluteal - muscle in the buttocks;
Granulation - tissue with blood vessels that grows to fill in deep wounds;
Hallucinations - hearing/seeing things that are not there;
Hct - hematocrit
Hgb - hemoglobin (protein in red blood cells to carry oxygen from lungs to the body);
HIPAA (Health Insurance Portability and Accountability Act) - law protecting healthcare information;
Hospice-end of life care;
HTN (Hypertension) - high blood pressure;
Hydraguard - cream used on the skin to protect it from irritants/moisture;
Hyperlipidemia - abnormally elevated levels of lipids in the blood;
Ibuprofen/Motrin-medication to relive pain and muscle cramps;
i.e. - that is;
Incontinence - loss of control of bladder and/or bowel function;

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F 000	Continued From page 4	F 000		

lbs - pounds;
LAL - low air loss mattress;
MASD - Moisture Associated Skin Dermatitis;
MDS (Minimum Data Set) - standardized assessment forms used in nursing homes;
Meatus - natural body opening or canal leading to the bladder;
Medihoney - honey products for the management of wounds and burns;
mL (milliliters) - unit of liquid volume, 5 ml equals 1 teaspoon;
mm (millimeter) - unit of length;
Moderate Cognitive Impairment - decisions poor, cues / supervision required;
Morphine - strong pain medication;
Motrin - medication to reduce swelling / pain;
Mottled - blotchy discoloration of skin;
MVI - multivitamin;
Neuropedic bed - motorized bed designed for use by individuals with physical, respiratory, or digestive disabilities;
NPUAP-national pressure ulcer advisory panel;
OOB - out of bed;
Oriented x 3 - aware of person, place and time/date;
Osteopenia-bone loss;
Parkinsons - a disease that affects movement, slow shuffle walk;
post-after;
PRN - as needed;
Pre-albumin - blood test to measure nutritional status;
Pressure Ulcers (PUs) - sore area of skin that develops when blood supply to it is cut off due to pressure;
Psychiatrist - physician for treatment of mental disorders;
Psychological (psych) - related to emotional and mental state of a person;

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Psychosis - loss of contact/touch with reality;
Puree - food blended into a smooth, creamy texture like mashed potatoes;
Retention - to hold in, unable to empty bladder completely;
Roho - pressure reducing cushion;
Sacral - large triangular bone at base of spine;
Serosanguineous - drainage containing watery serous (clear) fluid and blood;
Severe Cognitive Impairment - unable to make own decisions;
Shingles - painful open sores from virus that causes chicken pox;
Silvadene- antibacterial cream used to prevent and treat wound infections;
SOM (State Operations Manual) - book with regulations and guidance for surveyors;
s/s-signs and symptoms;
Stages (severity) of pressure ulcers (PUs):
Stage I (1) - intact red skin often over a boney area that does not turn white/light (blanche) when pressed.
Stage II (2) - blister or shallow open sore with red/pink color.
Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin.
Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt.
Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough.
Deep Tissue Injury (DTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue.

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F 000	Continued From page 6 supplement - addition to diet to enhance nutrition; Tylenol-medication for pain, fever; TID - three times a day; Trough - device for an arm of a chair to be positioned in a long narrow cushion; UTI-urinary tract infection; Venelex - cream for use on skin for the management of chronic and acute wounds; White Blood Count - a lab to help diagnosis of infection (higher number indicates infection); x - times; x-ray - picture of inside the body; Zinc oxide - barrier cream to protect skin from moisture and irritants.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		11/26/18

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F 550	Continued From page 7 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to treat two (R82, and R98) out of 45 sampled residents with respect and dignity, by not asking nor receiving permission before entering the room or failing to ensure privacy was protected by leaving the resident's exposed back area visible to the hallway. Findings include: 1. During an initial pool interview on 8/28/18 at 9:03 AM with R82, E14 (CNA) knocked on R82's closed room door, then opened the door and entered without permission. S/he walked to R82's roommate, placed linen on the bed and then exited the room. During an interview on 9/6/18 at 11:30 AM with E6 (RN) and staff educator it was confirmed that all CNA's upon hire receive in-service training entitled "Dignity." The Dignity inservice completed	F 550	#1 1. R82 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3 below. 3. Staff Developer will educate existing nursing staff on resident's rights, dignity, and respect. This education will include asking resident for permission to enter a resident's room. This education is included in new hire orientation and Annual Mandatory requirement which is conducted yearly. The facility will also purchase magnetic visual reminders for each door as a reminder to ask for permission to enter the room.	

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F 550	Continued From page 8 by E14 as a new hire, included the following: "we must stop knock and ask to enter before entering residents room." 2. During an observation on 8/29/18 between 9:50 AM-10:00 AM, R98 (B bed) was lying facing away from the doorway with a family member and E15 (MD) at bedside. R98 was uncovered with bare back and disposable brief visible from hallway. During an interview on 8/29/18 at 11:00 AM with E15, it was confirmed that R98's back and brief were exposed and visible from the hallway because E15 did not close the curtain. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 550	4. Staff educator/designee to perform random staff observations to ensure that residents are addressed with dignity and respect. Three random staff member observations will be done daily or until 100% compliance is achieved for three consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three staff observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QAPI monthly. #2 1. R98 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3 below. 3. The Medical Director educated the provider on 8/29/18 on resident's rights, dignity, and respect and to pull the privacy curtain when examining a resident. 4. Staff educator/designee to perform random staff observations to ensure that residents are addressed with dignity and respect. Three random staff member observations will be done daily or until 100% compliance is achieved for three	

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F 550	Continued From page 9	F 550	consecutive days. Observations will then be done three times weekly or until 100% compliance is reached for three consecutive times. Observations will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three staff observations are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QAPI monthly.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident	F 553		11/26/18

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F 553	Continued From page 10 of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to notify the resident / family member in advance of a change in treatment for one (R101) out of 45 sampled residents. Findings include: Review of R101's clinical record revealed: 8/12/18 - Admission to facility after hospitalization. 8/1918 - Admission MDS Assessment documented the resident was cognitively intact with a BIMS of 15. 8/27/18 (3:29 PM) - Physicians' order entered directly into the computer by the physician increased the blood pressure medication starting at 6:00 AM the next morning. 8/28/18 (6:08 AM) Nursing progress note - R101 had questions about the change in [name of medication] dosage and would like to speak with the physician in person before taking the new dose. 8/28/18 (8:22 AM) Nursing progress note - Nurse discussed with the resident that [name of	F 553	1. R101 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in #3. 3. Staff educator, along with the Medical Director, will educate licensed nursing staff and Provider on the right to participate in planning care and notification of medication changes when ordered. A house sweep was conducted and it was determined that no other residents were identified as not being made aware of medication changes. 4. DON/Designee to perform random audits of resident's right to participate in plan of care. Three random audits of residents performed daily times 5 days or until 100% compliance is achieved for 5 consecutive days. Random audits performed 3 times weekly until 100% compliance is reached for 3 consecutive times. Resident audits will continue at 1 time per week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident audits are 100%	

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F 553	Continued From page 11 medication] was increased as R101's blood pressures had been running high. Resident in agreement to taking the medication at this time. 8/28/18 (10:44 AM) Interview with resident during the initial pool - R101 said "they usually call my son with changes and he calls me." This morning "I was surprised when they increased by blood pressure medication." R101 added that s/he had not been called by the son. Resident stated s/he wanted to take the usual dose (2 capsules) instead of the higher (3 capsules) dose but they said to either "take it" or I would "get nothing." Review of progress notes found no evidence that the son or the resident was informed of the change in blood pressure medication. 8/29/18 (11:20 AM) - Interview with E5 (UM) to review the notification process. E5 stated s/he believed the physician told the resident directly. E5 added that some times "I inform the family even though the resident is their own responsible party." E5 confirmed there was nothing in the record about calling the son or the resident. 8/29/18 (11:55 AM) - Interview with E15 (physician) revealed that E15 did not inform the resident directly. E15 added that when at the facility late in the day the physician would discuss with the resident the next morning but R101 was not in her room. This finding was reviewed with E1 (NHA) and E2 (DON) on 9/6/18 during the exit conference at 2:00 PM.	F 553	compliant in one month the deficiency will be considered resolved.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		11/26/18

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F 580	Continued From page 12 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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	085052	A. BUILDING _____ B. WING _____	C 09/06/2018

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F 580	Continued From page 13 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that the facility failed to immediately consult the resident's physician of a significant change in status for one (R105) out of 45 sampled residents. R105 had a new onset of acute pain of the right hip and a change in mobility and the facility failed to consult the attending physician. Findings include: Cross refer F697, example #1. Facility Policy for Provider Notification of Resident Change in Medical Condition (revised 6/7/18) stated: Changes in a resident's medical condition are communicated to physicians in a timely and accurate manner and that a resident experiencing a significant change in condition is monitored continuously until the resident is stable or transferred to another level of care..Staff will notify the provider and applicable POA/responsible parties of:...significant change in condition in physical, mental or psychosocial status. or social status..." 4/5/18 Facility Event Report (closed 4/13/18): - E2 (DON) wrote: After extensive investigation,	F 580	1. R105 is deceased. 2. All residents who have pain the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3 below. 3. Staff Educator will educate existing licensed nursing staff on physician notification of changes in condition when warranted. Cadia's notification of changes policy will be used when educating licensed nursing staff on Physician notification. A house wide sweep was reviewed and no other like residents were affected. 4. DON/Designee to perform random audits of notification of changes. Three random audit observations daily until 100% compliance is achieved for three consecutive days. Random audits will then be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three	

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F 580	Continued From page 14 R105 was admitted to [name of facility] on 4/15/15 for long-term care. On 1/22/18 she was transferred to our dementia unit related to her marked increase in confusion related to dementia. On 4/5/18 during the 11 PM -7 AM shift, R105 verbalized discomfort to the right hip. Interventions: She was assessed by the nurse and medicated. She was assessed by the NP who ordered an x-ray. The x-ray showed a broken right hip. She continues to receive Hospice services. She is receiving analgesic for her discomfort. Unknown etiology of fracture. ? Osteopenia (bone loss) ? Fall. Resident has been noted to crawl on the floor, and attempt to transfer herself from one surface to another. - E32 (RN Supervisor) wrote: On 4/4/18 R105 was seen self-propelling in hallway. Last rounds approximately 9:30 PM resident showed no signs of pain... - E30 (CNA) wrote: I worked 3:00 PM to 7:00 AM on 4/4/18 into 4/5/18. I did not have R105 on the 3:00 PM to 11:00 PM portion of my shift. I did rounds on her at 11:30 PM, and noticed her laying facing the window When I changed her she began to roll to her back she began to yell out in pain. I asked her what hurt. She was holding her right hip. I went and told the nurse. Everytime I changed her she complained about pain. I have patient on 11:00 PM - 7:00 AM often she always complains about some general discomfort, but last night was different. - E31 (LPN) wrote: "On 4/5/18 approximately 04 (4:00 AM) called to (R105's) room due to resident continue to complain about pain to right hip. Upon assessment resident refused to move right leg continue to state 'I can't, it hurt', no discoloration noticed only resident favoring right leg refused to lay anyway but on her left side with her knees bent almost in fetal position. I the writer gave	F 580	residents audits are 100% compliant in one month deficiency will be considered resolved.	

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F 580	Continued From page 15 resident PRN Tylenol, which was not effective, she received routine Tylenol, which was not effective, staff reported resident continued in pain to right side. approximately 0630 (6:30 AM) resident received PRN Motrin. I the writer documented and chart in Doctor Book to have resident assessed and passed in report at change of shift." Review of R105's clinical record revealed: 4/5/18 at 4:24 AM - Nursing Note: Resident received acetaminophen 650 mg due to complaint of pain to right hip during care. Resident has very little range of motion, refuse to move right leg due to complaint that it hurt. When asking resident to move her leg she stated "I can't it hurt". Will continue to monitor. 4/5/18 at 6:58 AM - Nursing Note: Resident continue to complain of pain to right hip. Resident received Ibuprofen 400 mg, which awaiting results at this time. Resident is laying on side. Will continue to monitor. 4/5/18 at 8:45 AM - Nursing Note: Resident lying in bed this morning complaining of pain all over, unable to straighten right leg. Resident has no redness swelling, discolorations, Notified Nurse Practitioner who came to assess and ordered a right hip x-ray to be done immediately. Resident given Ibuprofen at 6:30 AM this morning. Hospice nurse into see patient as well, will follow up with them with results. 4/5/18 at 3:00 PM - Nursing Note: Residents x-ray results received and reviewed by NP. Resident has a broken right hip.	F 580		

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F 580	Continued From page 16 9/5/18 at 10:45 AM - Interview with E2 (DON) confirmed R105's physician / nurse practitioner was not notified of new right hip pain and decreased function of right leg until 4/5/18 at 8:45 AM. Despite the fact that R105 had increased pain and decreased function of right leg first identified at 11:30 PM on 4/4/18, there was lack of evidence of notification R105's NP until 4/5/18 at 8:45 AM. Later is was discovered that R105 had a broken right hip. This finding was reviewed with E1 (NHA) and E2 (DON) on 9/6/18 during the exit conference at 2:00 PM.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		11/26/18

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F 583	Continued From page 17 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and facility documents it was determined that for one (R55) out of 39 sampled residents the facility failed to ensure R55's request for changing notification of medical information was acknowledged by the facility. Findings include: 12/29/17 - Admission to the facility. 1/15/18 - Admission MDS indicated cognitively intact. 7/6/18 - Quarterly MDS indicated cognitively intact. 6/7/18 to 9/6/18 - Review of progress notes did not reveal communication in reference to changing who would be notified of a change in status. 7/11/18 - Progress Note - The daughter did not attend the care plan meeting.	F 583	1. R55 was not impacted by this deficient practice. R55 face sheet was updated on 8/31/18 and resident was notified of the change by the Admissions Director. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing licensed nursing staff on personal privacy and confidentiality of records. The facility will notify the admission's director for all changes to the resident face sheets so that the face sheets are updated for resident preference for notification is accurate. 4. DON/Designee to perform random audits of personal privacy and confidentiality of records. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits	

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F 583	Continued From page 18 8/28/18 at 11:25 AM - During an interview R55 revealed she communicated to a facility nurse that she wanted the facility to stop contacting the daughter about everything without her permission. R55 stated that she understood why they contacted the daughter on everything initially because she was sick. R55 stated, "I am much better now". R55 further revealed the request was made in the last few months. R55 has not heard anything and notification had not changed. 8/30/18 at 9:20 AM - Interview with E4 (UM) revealed that they handle resident medical information if they request a change in notification and if the person were alert and oriented, we would honor their wishes as to privacy. It was further revealed that E4 was not aware of a request made by R55. 8/30/18 - 1:47 PM - Interview with E16 (Admissions Office), revealed that on admission the HIPPA Form is signed and confidentiality handled based on the HIPPA Form. If R55 expressed that she would like to receive her information before her family due to her feeling more independent they would revisit the HIPPA form. 9/6/18 at 1:50 PM - A final interview with R55 revealed that to date no one had spoken with her about changing notification of medical care and services. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 583	will then be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Resident audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		11/26/18

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F 641	Continued From page 19 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately access one (R66) out of 45 sampled residents. Findings include:. Review of R66's clinical record revealed: 10/25/17 at 3:37 PM - Facility documentation - R66 fell during a transfer. 11/3/17 at 4:00 PM - Facility documentation - R66 had an unwitnessed fall. 1/16/18 - MDS indicates that the resident has not had any falls since admission or the prior assessment 9/5/18 at 12:08 PM - During an interview with E9 (RNAC) and E20 (RNAC) it was confirmed that the falls for 10/25/17 and 11/3/17 were not identified on the quarterly MDS of 1/16/18. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 641	1.R66 was not negatively impacted by this deficient practice. 2.All residents that have had a fall have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. Corporate Assessment Coordinator will educate Assessment Coordinators on accuracy of coding the MDS assessment. The facility has determined that the current process for coding falls was not in place to accurately code the MDS. The new process for coding falls on the MDS will include that each Assessment Coordinator will go into the Electronic Medical Record Event Report to assess if the resident had a fall during the assessment period to accurately code a fall episode for the MDS. 4. Corporate Assessment Coordinator will perform random audits on accuracy of fall episodes on the MDS. Three random resident audits will be performed daily or until 100% compliance is reached for 3 consecutive days. Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3	

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F 641	Continued From page 20	F 641	resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		11/26/18

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F 656	Continued From page 21 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of other facility documentation it was determined that for three (R23, R105 and R66) out of 45 sampled residents the facility failed to develop and implement comprehensive care plans with measurable goals in the areas of accident hazards (R23 and R105), fragile skin (R23)) and positioning (R66). Findings include: 1a. The following was reviewed in R23's clinical record: 3/7/18 - Admitted to the facility. 3/8/18 - Care plans for actual fall and potential for future falls related to weakness, decreased mobility, side effects from medications, Parkinsons (actual fall 6/4/18). Goal that (resident name) will have no injury related to falls x 90 days. The care plan failed to address not having falls. 3/14/18 - Admission MDS documented moderate cognitive impairment, R23 needed extensive assistance with transfers, did not walk, fell in the last month and 2-6 months prior to admission and no falls since admission. 9/6/18 10:15 AM - Findings reviewed with E2,	F 656	#1 1. R23 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing nursing staff on developing and implementing comprehensive care plans. A house wide was conducted and no other resident care plans were found to be deficient. Going forward, all residents who have had a fall in the facility will have a review of the care plan to assess if the care plan goal is individualized for the resident. These residents will be reviewed in the weekly High Risk Meeting. 4. DON/Designee will perform random audits on the development and implementation on comprehensive care plans. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1	

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F 656	Continued From page 22 E22 (Director of Clinical Services), E21 (Medical Director). No further information was available related to the care plan goal. b. 6/13/18 - Quarterly MDS for R23 documented a skin tear. 7/5/18 Admission Assessment documented - Green discoloration on back of right hand 3 inch by 5 inch. 7/5/18 - Hospital report sheet documented a left hand skin tear. 8/24/18 - R23's care plan for potential for infection related to skin tear to right upper arm initiated (over 2 months later) and discontinued on 8/31/18 as resolved. Although R23 has had ongoing skin tears and bruising, the facility failed to develop a care plan for preventative measures for fragile skin. Cross refer to F689, example # 1 2. The following was reviewed in R105's clinical record: 4/15/15 - R105 originally admitted to facility with diagnoses including failure to thrive and dementia. 4/15/15 (last edited 4/11/18): Care plan for potential for falls related to impaired mobility/weakness/antidepressants. -Since 12/1/17, R105 had actual falls on 12/4/17, 12/18/17, 1/29/18, 1/30/18, 2/6/18, twice on 3/3/18, 3/12/18, 3/13/18, 3/22/18, 3/27/18 and 3/28/18. -Goal (last edited 2/13/18): R105 will have no serious injury related to falls for 90 days.	F 656	time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved. #2 1. R105 were not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing staff on developing and implementing comprehensive care plans. A house wide was conducted and no other resident care plans were found to be deficient. Going forward, all residents who have had a fall in the facility will have a review of the care plan to assess if the care plan goal is individualized for each resident. These residents will be reviewed in the weekly High Risk Meeting. 4. DON/Designee will perform random audits on the development and implementation on comprehensive care plans. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100%	

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F 656	Continued From page 23 7/7/15 (last edited 2/13/18): Care plan for history of actual fall related to noncompliance use of call bell when needing assisstance. -Goal (last edited 2/13/18): R105 will have no serious injury related to falls for 90 days. 2/4/18 - Significant Change MDS documented severe cognitive impairment, extensive assistance with transfers, did not walk, fall in the last month and 2-6 months prior to admission and 2 or more falls since admission. R105's care plan goals only addressed not having injury from falls, it failed to address not having falls. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM. 3. Review of R66's clinical record revealed: 8/25/17 -- Care plan intervention - Adaptive equipment/splints as ordered. The care plan does not include positioning to address the left arm tray or a blue trough for R66's physical needs. Care Plan last revised 7/25/18. 6/14/18 - Physicians order: Patient to sit in high back reclining wheel chair with cushion and left arm tray continuously. 8/28/18 - 9/6/18 - Point of Care History Report indicated that R66 is to have left arm tray support on wheel chair when out of bed. 9/5/18 at 10:31 AM - Interview with E24 (CNA) in reference to the blue cushion that is in use and it was confirmed that it was a new trough cushion.	F 656	compliant in one month the deficiency will be considered resolved. #3 1. R66 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing staff on developing and implementing comprehensive care plans. A house wide sweep was conducted and no other residents were affected by this deficient practice. All residents who have a arm trough ordered will have the associated care plan updated and individualized according to the Physician order. 4. Therapy Director/Designee will perform random audits on the development and implementation on comprehensive care plans. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved.	

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F 656	Continued From page 24 E24 further revealed that the nurse had to check to make sure it was applied correctly this morning as this was not her typical assignment. 9/5/18 at 10:42 AM - Interview with E23 (OT) revealed that R66 was in speech therapy for an evaluation on Monday. E23 noticed that R66 was slumped over and thought the blue trough would work better than the green left arm tray. It was confirmed that there was no order for the trough and no care plan for the trough or left arm tray. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		11/26/18

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F 657	Continued From page 25 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan for two (R105 and R8) out of 45 sampled residents to reflect current status and needs related to fall prevention. Findings include: 1. R8's fall care plan was updated after a fall with major injury. The intervention put into place during this revision was not appropriate to the most recent fall. 3/12/18 11:42 AM - Progress notes - "Staff was assisting patient into shower room for care, resident became weak and fell to floor on right side she did not hit her head." 8/22/18 (last reviewed/revised) Care Plan: Category: Falls. Approaches added are: - 3/19/18 Fall mats x 2 when in bed to lessen the risk of serious injury (post-fall 03/12/18). - 3/12/18 Staff to encourage R8 to wear non-skid footwear. Two approaches were added to R8's care plan following a fall with major injury. Neither approach was appropriate to R8's recent fall in the shower, with staff assitance. Cross refer to F689, example # 1 2. The following was reviewed in R105's clinical record: 4/15/15 (last edited 4/11/18): Care plan for	F 657	#1 1. R8 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing licensed nursing staff son care plan timing and revision. The facility will review all residents who fell in the facility weekly during the " High Risk Meeting" to assure that all fall care plans with new interventions are documented on the resident care plan and are individualized. 4. DON/Designee will perform random audits of care plan timing and revision. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved.	

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F 657	Continued From page 26 potential for falls with approaches added before 12/1/18 included: call bell with in reach, ensure proper footwear, keep frequently used items within reach, safety device(s) as ordered, anti-rollbacks to wheelchair (discontinued with highback wheelchair on 3/29/18), therapy screen for transfer status and evaluation for need of dycem on wheelchair, educate on transferring without assistance, place signs in the room reminding her to call for assisstance with ambulation and and encourage family to give R105 frequent rest periods when on leave of absence for prolonged periods. 7/7/15 (last edited 2/13/18): Care plan for history of actual fall related to noncompliance use of call bell when needing assisstance. Approaches (not edited since 10/25/17) included: reinforce need to call for assistance, R105 to wear proper and non-slip footwear, keep room well lit and clutter free, keep call bell within reach, keep bed in lowest position that is appropriate, have commonly used articles within easy reach, ensure environment is free of clutter, and encourage R105 to use handrails or assistive devices properly. 12/1/17 - 4/3/18: Review of facility's investigations showed R105 had 12 unwitnessed falls in 4 months. 2/4/18 - Significant Change MDS documented severe cognitive impairment, extensive assistance with transfers, did not walk, fall in the last month and 2-6 months prior to admission and 2 or more falls since admission. 9/5/18 at 10:45 AM - Interview with E2 (DON) and E25 (PT, Rehab Director): Interventions to	F 657	#2 R105 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing staff on care plan timing and revision. The facility will review all residents who fell in the facility during the " High Risk Meeting" to assure that all fall care plans with new interventions are documented on the resident care plan and are individualized. 4. DON/Designee will perform random audits of care plan timing and revision. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved.	

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F 657	Continued From page 27 prevent falls were discussed, that included more frequent monitoring, but this was not added to R105's care plan. Despite 12 unwitnessed falls in 4 months (over half occurring within an hour of shift change), the facility failed to revise R105's care plan to include interventions such as increasing resident supervision, do not leave alone in bathroom and use of hipsters. These findings were reviewed with E1 (NHA) and E2 during exit conference on 9/6/18 at 2:00 PM.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R52 and R66) out of 45 residents the facility failed to follow the plan of care as ordered by the physician. For R 54, the facility failed to implement the bowel protocol. For R66 the facility failed to follow the physician's order for the left arm tray. Findings include: 1. Review of R54's clinical record revealed: 1/9/15 - Admission to facility.	F 684	#1 1. R54 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. Staff Educator will educate existing licensed nursing staff on implementation of the bowel protocol. The root cause	11/26/18

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F 684	Continued From page 28 4/13/15 - Care plan for potential for constipation. included the intervention to initiate bowel protocol according to the laxative list. 10/19/16 - Physicians' orders included bowel protocol: - MOM (Milk of Magnesia) once a day PRN if no bowel movement in 3 days. - Dulcolax suppository once a day PRN if no effect from MOM - Fleets enema once a day PRN if no effect from suppository. April, 2018 - August 2018 - Review of PRN eMAR and nursing progress notes revealed R54 usually had large bowel movements: - April 18: large BM, 4/22 MOM given producing a small BM. No evidence other steps of the bowel protocol were implemented in response to the small BM. R54 had a large BM April 25, six days after the previous large bowel movement. - June 7: large BM, 6/11 MOM (not recorded on the eMAR) resulted in small BM. 6/12 Nursing progress note documented "still on BM list." No evidence other steps of bowel protocol implemented. - July 12: Large BM, 7/15 small BM, 7/19 large BM 7/19, six days after the previous large BM. No evidence of bowel protocol implementation in the record. 8/31/18 (untimed) - Interview with E2 (DON) to discuss if small bowel movements count for the bowel protocol. E2 stated small BMs would count if the resident usually would have small or medium BMs. When asked if a resident usually had large BMs, E2 confirmed that a small BM would not count for this resident.	F 684	analysis determined that the facility did not monitor if nursing staff followed up with the resident having a bowel movement during the shift. No other residents were determined to be affected by this practice. Each nurse manager/Supervisor will run a electronic report through the facility EHR to determine the need to initiate the bowel protocol for all like residents. 4. DON/Designee will perform random audits of implementation of bowel protocol. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved. #2 1. R66 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below #3. 3. It was determined that the facility failed to place the arm tray on the wheelchair while sitting at the dining table causing the resident to lean to one side. No other residents were found to be affected by this	

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F 684	Continued From page 29 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews including bowel protocol implementation. 2. Review of R66's clinical record revealed: Findings include: 8/25/17 - Care plan intervention - Adaptive equipment/splints as ordered. 6/14/18 - Physician's order: Patient to sit in high back reclining wheel chair with cushion and left arm tray continuously. 8/28/18 - 9/6/18 - Point of Care History Report indicated that R66 is to have left arm tray support on wheel chair when out of bed. Observations: 8/28/18 at 10:30 AM - R66 in dining room slumped over to left in wheel chair. 8/29/18 at 12:05 PM - R66 in dining room slumped over to left in wheel chair. 8/29/18 at 12:12 PM - The family visiting had inquired if R66 was slumped over in the chair all day. Staff response she ate all her breakfast this morning. The family replied, " I do not care if she ate her breakfast has she been slumped like this all morning?" Yesterday "she arrived to a doctor's appointment like this" and I cannot believe they put her on the shuttle slumped over in the same way. Staff replied that R66 was positioned when she left the facility.	F 684	practice. The Therapy Director completed a house wide sweep to determine if there were like residents. Residents with a arm tray/trough will have an order and a schedule documented as to when the device can be removed or placed. Also, a therapy screen will be completed to determine other measures for positioning. 4. Therapy Director/Designee will perform random audits of implementation of adaptive equipment as ordered. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved.	

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F 684	Continued From page 30 8/29/18 at 12:17 PM - The family placed a green tray cushion on wheelchair and it assisted R66 to an upright position. Family spoke to and encouraged R66 to pick up her head. 8/30/18 9:25 AM, 10:42 AM, 11:40 AM, 12:01 PM, 12:11 PM, 12:29 PM: - R66 in Fenwick dining room slumped over to the left in chair while family member was visiting and talking. 8/31/18 9:10 AM - R66 in Fenwick dining room with the green left arm tray in place. 9/4/18 at 12:00 PM - A blue cushion in place under the left arm. 9/5/18 at 10:03 AM - A blue cushion in place under the left arm. The cushion was slipping out from under her arm and R66 was slumped over to the right. 9/5/18 at 12:10 PM - R66 in the dining room and the left arm is out of blue cushion. 9/5/18 at 10:31 AM - Interview with E24 (CNA) in reference to the blue cushion that was in use and E24 confirmed that it was a new trough cushion. E24 further revealed that the nurse had to check to make sure it was in place correctly this morning, as this was not her typical assignment. 9/5/18 at 10:42 AM - Interview with E23 (OT) revealed that R66 was in speech therapy for an evaluation on Monday. E23 noticed that R66 was slumped over and thought the blue trough would work better than the green left arm tray. It was confirmed that there was no order for the trough and no care plan for the trough or left arm tray.	F 684		

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F 684	Continued From page 31 These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R23) out of 45 sampled residents the facility failed to prevent the development of and promote the healing of pressure ulcers (PU). The facility failed to implement preventative and protective treatments. The facility failed to thoroughly assess skin post hospitalization after a pressure area was identified by the hospital. Findings include: Information from NPUAP states: Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and	F 686	1. R23 Wound was healed on 9/21/18. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below 3. Staff Educator/designee will educate licensed nursing staff on completing a thorough skin assessment on admission/readmission to the facility. The education will include a thorough description of the appearance of the wound. The Facility wound team will then assess and document the staging and all characteristics of the identified wound(s)	11/26/18

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F 686	Continued From page 32 epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. NPUAP.org 1. The following was reviewed in R23's clinical record: 3/7/18 - Admission Assessment documented redness to sacrum; redness/boggy (soft) heels, groin red. 3/14/18 - Admission MDS indicates at risk for pressure ulcers but no current wounds and requires extensive assistance with bed mobility and transfers. 3/14/18 - Care plan for Skin - Potential for altered skin integrity related to MASD rash to bilateral buttocks edited 8/29/18 approaches include: -Albumin, pre-albumin (4/25/18) -low air loss mattress (LAL) to bed, check functioning every shift (4/25/18) -Keep area clean and dry -Monitor site for changes in condition or non healing progress -Ointments/creams as ordered to affected areas: Apply Zinc oxide to buttocks every shift and PRN (edited 8/29/18) 3/19/18 - Care plan PU potential for PU related to decreased functional mobility approaches included: -encourage to eat lunch at private dining room.	F 686	to appropriately document and treat. 4. DON/Designee will perform random audits of new admisssions to ensure appropriate treatment and services are ordered for the prevention and treatment of pressure ulcers and accurate admission skin assessments are completed. Three random resident audits will be performed daily or until 100% compliance is achieved for three consecutive days. Random audits will be performed 3 times weekly or until 100% compliance is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of three resident observations are 100% compliant in one month the deficiency will be considered resolved.	

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F 686	Continued From page 33 Encouraged on 8/23/18 - educated on importance to get OOB to maintain good skin integrity. Education completed on 8/23/18 - utilize wedge for turn and position - LAL mattress to bed. Check functioning every shift (3/28/18) - Braden (PU) risk assessment as ordered - Cushion to wheelchair as ordered: Roho (edited 8/24/18) - Encourage / off load heels when in bed - Encourage to turn and position every 2 hours and prn - Ensure measures are taken to prevent / reduce potential shearing or friction during transfers, repositioning, etc. - monitor adequate nutrition/hydration - Neuropedic bed provided - Skin checks every 2 and PRN - Weekly skin assessment. Report abnormal conditions to MD Physicians' orders: - 3/28 - 4/25/18: Silvadene to MASD on buttocks prior to zinc. - 3/28 - 7/1/18: low air loss mattress. - 4/25 - 5/2/18: Silvadene and zinc to MASD. - 5/2 - 5/9/19: Silvadene and zinc to MASD three times a day. 5/23/18 - Wound healing Solutions "fungal dermatitis - bilateral (both sides) gluteal planes" 6/6/18 - Wound healing Solutions...Prealbumin was 22.0; HGB/Hct 9.4/26.6...gluteal planes resolved...apply A&D ointment TID and prn incontinence; side to side turning in bed. There was no evidence the side to side turning	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 34 was initiated. It was not included in the MD orders or the CNA tasks. 7/1 - 7/5/18 - Admitted to the hospital. 7/2/18 - Hospital Consultation...There has been no reported leakage around the catheter(tube to drain urine)...(MD name), urology. 7/5/18 - Cadia Hospital Report "UTI related to chronic Foley"..."has not gotten out of bed. No PT in hospital" ...skin integrity / open areas "Venelex - Sacrum; Left hand skin tear"... 7/5/18 Hospital record - Sacrum midline flat, pink, purple, pressure injury, intact dry; boney prominence, suspected deep tissue injury, improving, castor oil/balsam Peru topical (Venelex) 12 cm x 7 cm x 0 cm. 7/5/18 - Discharge Summary hospital Discharge orders: Outpatient Wound Care Center Special instructions: sacrum and bilateral buttocks - DTI (deep tissue injury) (Name of Hospital) Wound Care 1 to 2 weeks 7/5/18 admit to facility from hospital with primary diagnosis of urinary tract infection (UTI). 7/5/18 Admission Assessment documented - Stretched and irritated meatus. Green discoloration on back of right hand 3 inch by 5 inch. There was no mention of the sacral / buttocks / gluteal area. The surveyor was unable to determine if this area was assessed. 7/5/18 - Braden PU risk score of 16 indicating at risk.	F 686		

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F 686	Continued From page 35 7/5/18 - MD order for hydraguard to perineal area. 7/5/18 - Re-admission History & Physical - no skin issue noted. The surveyor was unable to determine if this area was assessed. 7/7/18 - Weekly skin check- no skin issue documented. It was unclear how R23 left the hospital with a DTI and wound treatment and assessments at the facility identified no skin issues. 7/14/18 - No weekly skin check found. 7/17/18 - Weekly skin check - no skin issues. 7/24/18 - Weekly skin check - open area to penis; no mention of sacral / gluteal area. 7/27/18 - NP progress note - only skin issue from recent shingles not PU or sacral issues. 8/1/18 - NP progress note - no skin issues, mentions penis issue. 8/2/18 - Braden PU risk score 18 indicating at risk. Review of Weekly skin checks found "no issue" on August 7, 14 and 21, 2018 8/23/18 7:08 AM - Progress note state that "new small open area to body"...12:23 PM note documents new treatment to bilateral glutes. 8/24/18 (skin sheet print out provided by facility)	F 686		

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F 686	Continued From page 36 "mechanical abrasion 10 x 2.8 cm area of ecchymosis to left glute and 2.5 cm x 1 cm to right glute with several areas of demarcation. Moderate seroang (sic, serosanguinous) drainage. Periwound is mottled. Resident has been on LAL mattress for a long time. Area is painful on palpation". 8/24/18 - MD order utilize wedge for turn and reposition. 8/24/18 - Care plan for Potential for infection related deep abrasions of bilateral medial glutes. -120 ml medpass (supplement) twice a day, MVI (nutrients), encourage to get out of bed for lunch, LAL mattress to bed, monitor food and fluid intakes, monitor site.., treatment ...medihoney to wound bed ...cover with sacral foam dressing change daily. 8/28/18 - Weekly skin check - no issues noted. August - September - CNA tasks included: utilize wedge for turn and position, offer toileting every 2 and prn for bowels, fall precautions low bed and non skid footwear. lotion to body daily, am and pm mouth care, hydroguard to perineal area, off load heels, skin checks every 2 hour. There was no evidence that side to side turning was ever initiated. 6/1/18 - 8/29/1/8 - Review of progress notes lack evidence of catheter leakage or wetness to skin. 8/29/18 - MD Progress note "...There is a full thickness ulceration of the left gluteus gluteal region about 10 x 3 cm or (sic) area. Area is irregular mildly red to purplish discoloration. It is every day (sic) with scabbing over of what might	F 686		

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F 686	Continued From page 37 have been a skin laceration on the left gluteal fold. There were no drainage.... Moisture associated sacral area stage 2 with a healing skin laceration ulcer or tear...Offload pressure to affected area by positioning every 2 hours while awake encourage patient to be mostly as much as possible on his side until wound heals..." 8/30/18 1:20 PM - Interview with E35 (CNA) revealed that she only works about 2 times a month. She had resident Tuesday and today (8/30/18). She said that the resident has a large raw area, looks like skin was tearing off. I worked last month and it did not look like that back then. We were using zguard (zinc) cream and it was not open it was red purple in color and large at that time. E35 stated she washed the resident early this am because she was told someone was going to look at the wound, she did not put anything on it because the nurse is doing that now but no one has looked at wound yet today. 8/30/18 1:35 PM - Observed wound with E33 (Nurse), E35 and another surveyor. Large linear wound on left buttocks surrounded by pink/purple intact skin. Wound area very dark red in color and started to bleed when cleansed with wipes. On right side of buttocks round/oval area much smaller in size but wider. Surrounding skin pink and scaly in places, area looks almost scabbed or necrotic. E33 verbalized concerned about open bleeding since when the doctor looked at it yesterday it was not open. E33 went out to talk to E34 (RN) and revealed they were calling the doctor and hopefully, will know soon how to proceed with treatment. 8/30/18 3:05 PM - Interview with E33, E34, and E4 (UM) to review hospital documentation from	F 686		

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F 686	Continued From page 38 7/5/18 and lack of evidence of wound assessment on admission by facility. No further information was available other than documented dermatitis to the gluteal plane in May 2018. The next notation of skin issues for R23 was 8/24/18. 08/30/18 3:35 PM - Reviewed the above finding with E2 (DON). 8/31/18 Wound Consultants assessment - Full-thickness ulceration of left gluteus / gluteal region - 5.2 x 0.6 x 0.2 CM. Area of linear deep red tissue / purplish discoloration - epithelium (skin)abraded open in areas ...full-thickness ulceration of the right gluteus / gluteal region 2.2 x 3.1 cm - area scattered irregular deep red tissue / less purplish discoloration - epithelium abraded open in area...Plan: deep abrasions along bilateral gluteal regions - decreased tissue tolerances related to general decline...high risk for transition into pressure injury in spite of interventions... There was no documentation concerning wetness, leaking catheter or MASD. 8/31/18 - MD assessment of skin / wound - MASD perineal area with a few open areas improving from last week notes / exam per wound team; Agree with wound care team assessment of MASD as primary cause of perineal skin issues. Improving with treatment. Discussed other long term options to decrease moisture. May explore different mattress to provide even better air flow if it does not continue to improve with medihoney and dressing. No signs of infection. May want to talk to urologist if leaking remains a problem about other options than current FC (foley catheter). Will discuss with PCP/NP.	F 686		

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F 686	Continued From page 39 9/5/18 (approximately 3:30 PM) - Interview with E36 (CNA) revealed that R23's catheter does not leak, he is periodically incontinent of bowel but staff try to assist him to the toilet. This finding was reviewed with E1 (NHA) and E2 (DON) on 9/6/18 during the exit conference at 2:00 PM.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations, review of facility documentation and interviews, it was determined that for two (R23 and R105) out of 7 residents reviewed for falls, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents. For R105 the facility failed to provide adequate supervision to R105 when the resident sustained 12 falls in a 4 month period of time. For R23 the facility failed to determine the root cause of fall(s). Findings include: Facility Policy for Fall Prevention Resident Assessment and Management (revised 12/19/16): -A resident suspected of undergoing a fall is assessed by the nurse, MD/PA/NP. Residents are	F 689	#1 1. R105 No corrective action can be taken as she had expired prior to the survey on 4-18-18. 2. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined in #3 below. 3. Staff Developer will educate existing nursing staff in updating all fall care plans during the fall committee. It was determined that the facility did not update the fall Care Plan for the named resident and to determine a root cause analysis for frequent falls. Each Fall that occurs in the Center will be reviewed during the facility	11/26/18

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F 689	Continued From page 40 assessed prior to being moved from the fall location to determine if injury was sustained. -Unwitnessed Fall: A resident suspected of a fall without injury is placed back into bed or chair with the assistance of at least two staff members or via mechanical lift as dictated by resident condition. 1. The following was reviewed in R105's clinical record: 4/15/15 - R105 was originally admitted to facility with diagnoses including failure to thrive and dementia. 4/15/15 (last edited 4/11/18): Care plan for potential for falls related to impaired mobility/weakness/antidepressants. -Since 12/1/17, R105 had actual falls on 12/4/17, 12/18/17, 1/29/18, 1/30/18, 2/6/18, twice on 3/3/18, 3/12/18, 3/13/18, 3/22/18, 3/27/18 and 3/28/18. (total of 12 falls) -Goal (last edited 2/13/18): R105 will have no serious injury related to falls for 90 days. -Approaches added before 12/1/18 included: call bell with in reach, ensure proper footwear, keep frequently used items within reach, safety device(s) as ordered, anti-rollbacks to wheelchair (discontinued with highback wheelchair on 3/29/18), therapy screen for transfer status and evaluation for need of dycem on wheelchair, educate on transferring without assistance, place signs in the room reminding her to call for assisstance with ambulation and encourage family to give R105 frequent rest periods when on Leave of Absence for prolonged periods. 7/7/15 (last edited 2/13/18): Care plan for history of actual fall related to noncompliance use of call	F 689	High Risk Meeting and through the fall committee to determine causative factors as to why falls are occurring. 4. DON/designee to perform random resident fall audits to ensure nurse assessment was completed. Three random resident fall audits will be done daily or until 100% compliance is achieved for three consecutive days. Audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three resident fall audits are 100% compliant in one month the deficiency will be considered resolved. Results of audits will be presented at QAPI monthly. 2. 1. R23 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. 3. Staff Developer will educate existing nursing staff in obtaining witness statements from staff, residents themselves and other residents when an incident occurs. It was determined that the facility failed to complete a thorough investigation and obtaining all witness statements for a root cause analysis and a complete investigation. 4. DON/designee to perform random audits on falls to ensure that thorough	

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F 689	Continued From page 41 bell when needing assisstance. -Goal (last edited 2/13/18): R105 will have no serious injury related to falls for 90 days. -Approaches (not edited since 10/25/17) included: reinforce need to call for assistance, R105 to wear proper and non-slip footwear, keep room well lit and clutter free, keep call bell within reach, keep bed in lowest position that is appropriate, have commonly used articles within easy reach, ensure environment is free of clutter, and encourage R105 to use handrails or assistive devices properly. 2/4/18 - Significant Change MDS for starting hospice services documented severe cognitive impairment, extensive assistance with transfers, does not walk, fall in the last month and 2-6 months prior to admission and 2 or more falls since admission. 3/3/18 - Evaluation of Fall Assessment: Score of 14 and a score of greater than 10 is a high fall risk. 12/1/17 - 4/3/18: Review of facility's investigations of R105's 12 unwitnessed falls and interventions added after each fall: -12/4/17 at 9:58 AM : Found on floor beside her bed. R105 stated she was "trying to get away from spiders." No injury. Denied pain. Added to check urine for UTI (urinary tract infection) and to consult psychiatry. Added to care plan that resident is independent with bed mobility, limited assist with transfers and non-ambulatory. -12/18/17 at 7:57 PM (unwitnessed fall): Found half in and half out of bed. No injury. Added to post sign in a bright color "call for assistance", as a reminder. Initiated voiding diary. -1/29/18 at 10:04 AM (unwitnessed fall): Found	F 689	investigations are completed. Three random resident fall audits will be done daily or until 100% compliance is achieved for three consecutive days. Resident fall audits will then be done three times weekly or until 100% compliance is reached for three consecutive times. Resident fall audits will continue at one time a week for three consecutive weeks or until 100% compliant. If a random sample of three resident fall audits are 100% compliant in one month the deficiency will be considered resolved. Results of interviews will be presented at QAPI monthly.	

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F 689	Continued From page 42 kneeling next to bed. No injury. Denied pain. Was moved to Dementia Unit 1/22/18 and started on hospice. -1/30/18 at 2:41 PM (unwitnessed fall): Found sitting on the floor next to bed. No injury. Denied pain. Added to check urine for UTI. -2/6/18 at 8:00 AM (unwitnessed fall): Found sitting on the floor next to bed. No injury. Denied pain. Added to re-educate R105 on transferring without assistance and place signs in the room reminding her to call for assisstance with ambulation. -3/3/18 at 8:35 AM (unwitnessed fall): Found kneeling on the bathroom floor with pants around her ankles. R105 stated that she was trying to pull up her pants. No injury. Denied pain. Initiated voiding diary to reassess toilet program. Added motion sensing alarm to bathroom door. -3/3/18 at 3:15 PM (unwitnessed fall): Found sitting on the floor in bathroom doorway with no pants on and stool on her backside. No injury. Denied pain. Added motion sensing alarm to bathroom door. -3/12/18 at 5:27 PM (unwitnessed fall): Found on bathroom floor. Bathroom motion sensing alarm was not alarming. R105 complained of headache and right hip pain. x-ray negative for fracture. Staff education on re-setting Bathroom motion sensing alarm. -3/13/18 at 2:44 PM (unwitnessed fall): Found on the floor next to bed. She had been toileted prior to fall. R105 stated she was looking for keys so she could go get her car to leave. No injury. Denied pain. Added to place fall mats on floor on each side of bed when in bed. -3/22/18 at 11:03 PM (unwitnessed fall): After bathroom motion sensing alarm went off, found sitting on bathroom floor. No injury. Pain resolved after 24 hours. But, R105 stated her knees were	F 689		

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F 689	Continued From page 43 sore and she had crawled to the bathroom. She had been toileted 30 minutes before she was found in bathroom. Added to give snack. Reminded to call for assistance before ambulating. -3/27/18 at 11:08 PM (unwitnessed fall): Found lying on floor in hall near wheelchair. R105 stated that she slipped out of the wheelchair. No injury. Denied pain. Added to offer R105 to sit in recliner when she appears tired. -3/28/18 at 4:38 PM (unwitnessed fall): Found lying on floor in hall near wheelchair. R105 stated, "I was trying to pick something up off the floor and fell" but, nothing found on floor. Quarter size lump with abrasion noted on right side of forehead. Pain resolved after 24 hours. Added to offer R105 to rest in recliner after lunch and prn. 4/2/18 and 4/5/18: No progress notes documented in medical record. 4/5/18 Witness written statement by E26 (former CNA): On 4/4/18 at about 9:15 PM - 9:30 PM, R105 was found on the floor. When asked if she was ok, R105 said "Yes. I put my butt on the floor from the bed and crawled to bathroom." E26 stated, I put her back in bed after toileting her and she never complained of any new pain. 4/10/18 at 10:31 AM - Progress Note by E2 (DON): Met with resident's daughter regarding circumstances surrounding her mother's fracture. Discussed falls, transfers unassisted and crawling around on the floor in her room. Discussed hallucinations, delusions, anxiety, and irritability. Discussed R105's dementia and prognosis. 4/5/18 Facility Event Report (closed 4/13/18) - E2	F 689		

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F 689	Continued From page 44 (DON) wrote: After extensive investigation, R105 was admitted to Renaissance on 4/15/18 for long-term care. On 1/22/18 she was transferred to our Dementia unit related to her marked increase in confusion, hallucinations and delusions related to her Dementia. Her diagnoses include, but are not limited to, dementia with hallucinations, cognitive impairments, diabetes, and major depressive disorder, confusion, and anxiety. She has been impulsive and delusional as well as anxious. She recently had Hospice services added related to her decline. She is being followed by Psychological services. On 4/5/18 during the 11PM -7AM shift, she verbalized discomfort to her right hip. Interventions: She was assessed by the nurse and medicated. She was assessed by the Nurse Practitioner and an order for an x-ray was received. Her x-ray showed a broken right hip. Her family did not want her to have any further testing or procedures completed related to her continued decline. She continues to receive Hospice services. She is receiving analgesic for her discomfort. Unknown etiology of fracture. ? Osteopenia (bone loss). ? Fall. Resident has been noted to crawl on the floor, and attempt to transfer herself from one surface to another. 9/5/18 at 10:45 AM - Interview with E2 (DON) and E25 (PT, Rehab Director): Interventions to prevent falls were discussed that included more frequent monitoring but this was not written in R105's care plan and no evidence found in documentation that staff were monitoring R105 more frequently. E2 confirmed that the above written statement was submitted to her from E26 (former CNA); however, E2 stated that based on interviews with E26 and other witness statements they could not confirm that R105 was found on	F 689		

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F 689	Continued From page 45 the floor on 4/4/18 by E26. Therefore, E2 stated their investigation was unable to determine the cause of R105's broken right hip. Despite 12 falls in 4 months (over half occurring within an hour of shift change), the facility failed to revise R105's plan of care to include interventions such as increasing resident supervision, do not leave alone in bathroom and use of hipsters. In addition, E26 wrote in a statement that after she found resident on floor on 4/4/18, she moved R105 back in bed after toileting her which is against facility policy for an unwitnessed fall. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM. 2. The following was reviewed in R23's clinical record: 3/7/18 - Admitted to the facility. 3/8/18 - Care plan for falls actual fall and potential for future falls related to weakness, decreased mobility, side effects from medication, Parkinsons (actual fall 6/4/18) interventions included: -re-educated to avoid leaning over wheelchair 6/6/18, encourage to use handrails or assistive devices properly, clutter free, commonly used articles in reach, low bed, call bell in reach, well lit, proper foot ware, pt/ot eval prn, reinforce need to call for assistance. 3/14/18 - Admission MDS documented moderate cognitive impairment, extensive assistance with transfers, does not walk, fall in the last month and 2-6 months prior to admission and no falls since	F 689		

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CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

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F 689	Continued From page 46 admission. 6/4/18 10:13 PM - Progress note resident fell out of wheelchair in dining room to floor at 5:30 PM. Hit forehead left area, large bump. Skin tear to left elbow. Steri-strips applied. Fall was witnessed. Resident going back to room. Denied pain...Started neuro checks WNL... 6/6/18 - Incident Report Summary 6/4/18 fall at 5:30 PM in Fenwick dining room documented (resident name) reported that he was leaning over his wheelchair and fell forward onto the floor hitting his left elbow and the left side of his forehead...Skin tear to left elbow...toileted 1 hour before fall...witnessed but no statement noted. Review of the incident report lacked evidence that a thorough investigation of the root cause of the fall was conducted. There was not a complete interview with resident to determine the cause / contributing factors of the fall. The witness(s) to the fall were not interviewed. 6/6/18 - Facility Incident Investigation Summary documented under causes as determined by the investigation "(resident name) leaned over his wheelchair and fell forward to the floor" and corrective action "...education provided to resident to avoid leaning over his wheelchair...". 8/30/18 12:30 PM - Interview with R23 revealed he remembered the fall. R23 shared that he became weak trying to propel his wheelchair, he was leaning forward when he toppled over and fell to the floor. He stated "it was embarrassing, I was in the middle of the dining room". These findings were reviewed with E1 (NHA) and	F 689		

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F 689	Continued From page 47 E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		11/26/18

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F 690	Continued From page 48 possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for one (R257) out of 45 sampled residents, the facility failed to identify signs of a UTI timely and failed to provide care and services according to standards of practice after discontinuation of an indwelling urinary catheter. - R257 was harmed when the facility failed to recognize early signs of a UTI , obtain a urine culture and administer antibiotics timely: R257 felt "awful" and was hospitalized after the resident's blood pressure became low and R257 developed confusion (usually oriented) and lethargy. Additionally for R257 the facility failed to monitor post void residuals after discontinuation of a urinary catheter that was inserted for retention. R257's bladder did not empty and an undetermined amount of urine accumulated leading to lower abdominal pain on two separate occasions when the bladder was overly full with 1,000 mls of cloudy dark urine. Findings include: National Institute of Diabetes and Digestive and Kidney Diseases, a division of National Institutes of Health, information on bladder infections in adults identified risk factors for developing a urinary tract infection (UTI): female gender, inability to empty bladder completely and use of urinary catheter (R257 had all three risk factors). Untreated bladder infections can lead to kidney infection. Signs of a kidney infection included severe pain in the back near the ribs or in the lower abdomen, along with vomiting and nausea, fever may indicate a kidney infection. UTI prevention included drinking enough liquids (six to eight 8-ounce glasses of fluid), urinating often	F 690	1. R257's Urinary Tract infection (UTI) has been resolved. The indwelling urinary catheter that was inserted during her hospital stay has been removed. R257 is voiding without difficulty. 2. All residents with an indwelling catheter who require the use of an indwelling urinary catheter have the potential to be impacted by this deficient practice. 3. The root-cause analysis related to this citation revealed a knowledge deficit related to: monitoring of a resident status post removal/ discontinuation of an indwelling urinary catheter; recognition of possible signs / symptoms of a Urinary Tract Infection and diagnostic studies to determine the presence of an actual infection. The facility has instituted the following measures: a.) fluid intakes are now being documented during meals and when additional fluids are ordered. b.) A new protocol for Indwelling Urinary Catheter Removal was created. Education related to assessment for signs/ symptoms of a UTI, interventions to be taken when symptoms are present, notification of the Practitioner, and evaluation/ re-assessment of the effectiveness of the measures initiated will be conducted for the licensed nursing staff. The Staff Educator/ designee will provide training and determine competency in the areas noted above. 4. DON/Designee will audit residents who have had an indwelling catheter removed for compliance with the protocol for	

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F 690	Continued From page 49 and when the feeling to urinate first happens since bacteria can grow when urine stays in the bladder too long. https://www.niddk.nih.gov/health-information/urologic-diseases/bladder-infection-uti-in-adults - accessed 9/7/18. Review of R257's clinical record revealed: Hospital records documented the resident('s): - blood test on 8/16/18 showed kidney function was normal: BUN 14 (normal range 6-21), creatinine 0.8 (normal range 0.5 - 0.9). - received intravenous (IV) contrast on 8/17/18. - had a urinary catheter inserted at 4:00 AM on 8/20/18 for "retention" which was not assessed before discharge to the facility. - discharge summary by hospital physician did not include urine retention / catheter. 8/20/18 (1:00 PM) - Admitted to the long term care facility after hospitalization for a stroke. 8/20/18 - Admission physicians' orders included: - urinary catheter [specific size ordered]. - change catheter and drainage bag PRN. - record urinary and bowel output every shift. 8/20/18 - 8/25/18 - Review of R257's nursing progress notes and CNA documentation of temperatures indicated catheter drained clear dark yellow urine and R257 had elevated oral temperatures: August 20 (99.4 F), August 21 (100.3 F) and August 22 (101.8 F). [Elevated temperature can be a sign of an infection. Dark urine can be a sign of poor fluid intake.] 8/21/18 - Physicians' orders included diagnosis for catheter as bladder outlet obstruction.	F 690	Indwelling Urinary Catheter Removal. The protocol address resident assessment, interventions, and documentation status post the removal. For a 3 month period, all residents□ status post removal of the indwelling catheter will be audited on a daily basis for 7 days post removal to determine compliance. The results of the auditing will be reviewed during the facility Quality Assurance Performance Improvement meetings. Once compliance is meet consistently over a 3 month period the deficient practice will be deemed resolved.	

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F 690	Continued From page 50 8/21/18 - Physicians' orders included a urinalysis. [There was no evidence in the record that the urine test was ever obtained and completed.] 8/26/18 (8:54 PM) Nursing progress note - E17 (LPN) documented "Draining dark urine. Foley deflate and partially rearrange and inflated again." [The nurse did not identify the rationale for the adjustment of the catheter.] 8/28/18 (between 9:00 AM - 10:00 AM) - Surveyor observed E19 (RN) holding a specimen cup containing dark red liquid at the nursing station. E19 stated the liquid was R257's urine. 8/28/18 (3:45 PM) Care Conference note - "Patient was observed with blood in her urine. Her catheter was flushed today and her urine has been clear." [Review of progress notes and orders revealed no order to flush the catheter, that the physician was notified, nor was there documentation by E19 about the bloody urine. Bloody urine can be a sign of a UTI and no laboratory testing was done on the urine.] 8/29/18 Nursing Progress Notes and CNA documentation: - 9:44 AM: Resident catheter discontinued on prior shift. R257 had not urinated yet this morning and the resident stated s/he had not had much to drink that morning. Encouraging fluids. - 4:00 PM: resident urinated a "large" amount this afternoon. Fluids encouraged. - 10:22 PM: Passing "yellow mucousy urine." Pushing oral fluids. [mucous in urine may be a sign of a UTI and no testing done on the urine] There was no evidence in the record as to:	F 690		

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F 690	Continued From page 51 - the amount of urine in mLs R257 produced the first time after catheter removal (first void). - the number of mLs left in the bladder (post void residual) immediately after urination. - the amount of liquids R257 drank. - whether the physician was notified of the yellow "mucousy" urine. 8/29/18 (2:33 PM) - Interview with E11 (CNA) to review how R257 took oral fluids and about output since the catheter was discontinued. E11 stated R257 took fluids real well but needed reminders to drink. The CNA confirmed urine was not measured. When asked how the CNA determined the "large" amount, E11 stated s/he, along with E5 (UM), heard the resident urinate in the toilet and that it sounded like a large amount. 8/29/18 (approximately 2:50 PM) - Interview with E5 revealed monitoring intake and output was very rarely done unless the doctor specifically ordered it. 8/31/18 - Review of facility policy entitled Appropriate Indwelling Catheter Use (revised 3/16/17) which was presented to the surveyor in response to request for policy(ies) addressing monitoring after catheter removal, readjusting the catheter, and flushing the catheter. The policy addressed necessity for use, daily catheter care, changing of catheter/drainage bag and obtaining urine culture from a new catheter. [The policy did not address monitoring post void residuals, flushing the catheter or readjusting the catheter.] 8/31/18 - Review of physicians' orders and nursing progress notes found: - Blood test results (normal range): impaired kidney function: BUN 42 (7 - 17) ,	F 690		

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F 690	Continued From page 52 creatinine 2.2 (0.52 - 1.04), sodium 130 (137-145). infection: White Blood Count (WBC) 15.5 (3.7 - 8.9). - Physician ordered: IV fluids at 100 mL per hour for 3,000 mL total since R257 "not eating / drinking" [for kidney impairment / dehydration]. IV antibiotic ordered for elevated WBC [for infection]. urine culture [ordered three days after signs of a UTI of bloody and/or "mucousy" urine identified]. 9/1/18 (9:30 AM) Nursing progress note - R257 reported s/he "doesn't feel right." Temperature 100.6 F with lower abdomen tenderness. Bladderscan showed 875 mL. Encouraged to urinate on bedpan produced around 50 mL. [First evidence of measuring bladder residual.] 9/1/18 - Physicians' ordered straight catheterization (insert catheter to drain bladder, then immediately remove catheter) and stop IV fluids. Nursing Progress Notes / CNA documentation for temperatures/ urine output: - 9/1/18 (9:30 AM): Temperature 100.6 F. - 9/1/18 (9:45 AM): Bladder drained 1,000 mL (1 liter) of dark cloudy urine with reduction in abdominal discomfort. Tylenol given for fever. - 9/1/18 (11:30 AM - 11:45 AM): Temperature 98.4 F after Tylenol, blood pressure (BP) very low at 88/58. Physician on call notified, repeat vital signs in one hour. Daughter informed. - 9/1/18 (12:46 PM - 1:11 PM): BP remained low 94/55, temperature 97.4 F. Physician notified of BP and preliminary urine culture results with a	F 690		

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F 690	Continued From page 53 large amount of a bacteria. - 9/1/18 (2:07 PM): Output - Small, incontinent. - 9/1/18 (7:30 PM): Temperature 99 F. - 9/1/18 (10:55 PM): Output - None. - 9/2/18 (9:59 AM): Resident stated "feels awful." Edema 1-2 + generalized. [Edema can be a sign of impaired kidney function.] - 9/2/18 (11:29 AM - 12:34 PM): Resident complained abdominal pain and was confused (usually oriented x 3). Bladderscan showed over 600 mL. Temperature 98.2 F. - 9/2/18 (11:40 - 11:45 AM) Straight cathed for 1,000 mL dark cloudy urine. Report given to emergency department nurse. Sent 911 to hospital. 9/4/18 (1:15 PM) Interview with E17 to describe why the catheter was readjusted on August 26. E17 stated the "catheter was leaking a little." When asked how it was readjusted, the nurse said , s/he "cleaned the tube down to the end, deflated balloon pushed catheter in a little, then reinflated balloon." E17 added there was no more leaking. 9/4/18 (8:30 AM) - Observation of a stack of approximately ten specimen "hats" in central supply. 9/4/18 (3:05 PM) Interview with E15 (Physician). When asked about measuring urinary output after catheter removal, the physician indicated that "should get progressively more urine over the next 72 hours." Surveyor informed that R257's urine was recorded as small, medium and large by listening to the resident urinate in the toilet. The physician said that was "subjective" and "should be in mLs." Surveyor informed the physician that the facility had specimen hats for	F 690		

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F 690	Continued From page 54 colleting urine in toilets for measurement. Surveyor added that R257's intake went down and nursing documented they were pushing fluids, however no amount (outside the ordered amount on the MAR) was recorded. Surveyor described several instances when small or "none" urine output was recorded yet no evidence that the nurses were aware. E15 said "after hearing what you had to say I think I may change how I do things" (referring to measurements). 9/5/18 (8:38 AM) - Follow up interview with E11 (CNA), who was unable to describe how many mLs of urine equals small, medium and large voids. E11 said that when residents use the toilet it's hard to determine the amount and added mLs would be more accurate. E11 stated that output should be documented with every void. E11 added "We write how much" liquids are taken "if they have to have fluids." 9/5/18 (11:00 AM) - Interview with F1 (resident's family member) revealed R257 was admitted to the hospital with a UTI. F1 explained how the resident's blood tests were improving and that R 257 might be discharged today. F1 added that the "doctor at the hospital said the facility needs to keep an eye out for early detection of UTI, make sure hygiene is done and a voiding trial." 9/5/18 (11:20 AM) Interview with E21 (Medical Director), in the presence of E2 (DON), who explained that R257 had "dye [IV contrast] in the hospital. E21 admitted the resident had retention problems and added "I wish the hospital would have included that in their discharge summary." The resident's catheter was removed here and s/he "may not have been emptying her bladder which could have contributed to the renal	F 690		

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F 690	Continued From page 55 function. [When bladder full, urine can back up to the kidneys and cause impairment / injury.] The [name of antibiotic] that was started was correct for the organism in the urine." E21 added "after 3 liters of fluids her creatinine was still elevated (showing impaired kidney function) and wonder if there was kidney injury from the dye." There was no evidence that the facility reassessed kidney function during the first 10 days since admission. Kidney damage can be minimized with high intake of fluids to flush the contrast out of the body. 9/6/18 (8:50 AM) Interview with E22 (Director of Clinical Services) and E12 (Corporate Nurse). Surveyor explained s/he was interviewing staff to determine how intake and output was documented. E22 said "we started IVs and did a bladderscan." The surveyor discussed concern over the lack of routine monitoring of post void residuals after the catheter was discontinued. When E22 stated bladderscans were completed, the surveyor pointed out that bladderscans were done only in response to resident having abdominal pain from retaining urine. 9/6/16 - Review of the hospital records after the resident returned to the facility on 9/5/18 discovered when a urinary catheter was inserted in the emergency room "turbid, thick, purulent urine" was collected for testing. WBC high at 16.3 (infection) and impaired kidney function: BUN 47 (high), creatinine 2.31 (high), sodium 130 (low), potasium 5.5 (high). Will be hydrated for acute kidney injury. Upon discharge R257's kidney function was nearly normal: BUN 19, sodium 140, potassium 4.1 (all normal), creatinine 0.92 (little high).	F 690		

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F 690	Continued From page 56 The facility failed to identify early signs of a UTI and failed to routinely monitor R257's post (after) void residuals after discontinuation of the urinary catheter. R257 was harmed by these failures: - experienced abdominal pain and felt "awlful" on two separate occasions when bladder became overly full and 1,000 mLs of urine was drained each time. - experienced a decline in blood pressure and developed confusion and lethargy requiring hospitalization for treatment. It was unclear if hospitalization could have been avoided if the UTI was identified sooner, when the urinalysis was ordered 8/21/18, when bloody urine was discovered on 8/28/18 or when mucousy urine was observed on 8/29/18. Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 9/6/18 beginning at 2:00 PM.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		11/26/18

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F 692	Continued From page 57 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to maintain acceptable nutritional status for 1 (R100) out of 3 residents reviewed for nutrition. The facility failed to identify at least one severe weight loss, failed to identify an additional weight loss, failed to notify the off-site dietician of the weight losses and failed to report a lack in intake of nutritional supplements. Findings include: R100's clinical records revealed: 7/16/18 - Weight was 122.6 lbs. 8/6/18 - 8/12/18 - R100 was hospitalized. 8/12/18 Physicians Orders - Weekly weights, once a day on Monday. 8/13/18 - Weight was 121.6 lbs. 8/13 - 8/30/18 Physicians' Orders - Regular diet of pureed consistency and thin fluids. 8/15/18 12:32 PM Dietary Progress Note - R100 is 87 year old, with dementia, HTN, hyperlipidemia, anemia and anxiety and recently returned from acute care facility with diagnosis	F 692	1.R100 was not negatively impacted by this deficient practice. 2.All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. It was determined that the facility failed to identify weight loss, notify the dietician and to report fluid intake. The facility updated the point of care to document fluid intakes at meals. All weight declines will be reported in facility morning meeting and referred to the dietician for intervention and assessment. The Dietician will also participate in facility High risk meeting. 4. Dietitian/Designee will perform random audits on accuracy of communication for weight loss and lack of intake of nutritional supplements. Three random resident audits will be performed daily or until 100% compliance is reached for 3 consecutive days. Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100%	

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F 692	Continued From page 58 including A Fib. R100s weight history shows as stable with a BMI that remains within ideal range of 18.5 and 24.9. Diet downgraded to modified texture upon Resident's return with SLP working with Resident for possible diet advancement. Currently tolerating meal plan. Will add liquid supplement twice daily and will continue to monitor for significant changes reassessing as needed. 8/15/18 Physicians Orders - 120 mL supplement twice a day. 8/16/18 - Nutritional Care Plan with goal that oral intake will continue to meet at least 76% estimated nutrient needs for improving strength, promoting good skin integrity, and maintaining good fluid balance with no s/s of dehydration through next review period. 8/20/18 - Weight was 116 lbs. This is a weight loss of 4.6% (8/13/18). No evidence was found of identifying this weight loss. 8/27/18 - Weight recorded as "Not Taken." 8/30/18 - 9/5/18 Physicians' Orders - Regular diet of pureed consistency and thin fluids. 9/1/18 - Weight is 112.2 lbs. This was a severe weight loss of 7.73% in less than a month (8/13/18). No evidence was found of identifying this weight loss. 9/3/18 - Weight was 115.6 lbs. This was a weight loss of 4.93% in less than a month (8/13/16). No evidence was found of identifying this additional weight loss. No dietary progress notes are made between 8/15/18 and 9/4/18. 8/16 - 9/4/18 - Supplement intake averages 48%	F 692	compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	

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F 692	Continued From page 59 with 17 refusals out of 40 administrations, 19 times out of 40 administrations R100 drank the entire supplement, and 3 times out of 40 administrations R100 drank a partial supplement. No evidence was found of identifying the lack of supplement intake. 9/4/18 11:35 AM - During an interview, E2 (DON) explained that E18 (RD) generated a report of resident's weights. This is done quarterly or monthly, depending on when weights are ordered on the resident. 9/4/18 1:00 PM - During a phone interview, E18 explained that nutritional assessments were completed every three months, unless there is a significant weight change. E18 would be notified of this change (E18 works remotely and does not visit the facility) and make an extended progress note in response. E18 confirms that there was no notification of R100's weight losses on 8/20/18, 9/1/18, or 9/3/18. 9/5/18 Physicians Orders - Regular diet of pureed consistency and thin fluids. *May have mechanical soft breads, cookies, banana with staff supervision* E18 completed a dietary progress note on 9/4/18 at 9:17 PM noting weight loss of 4.9% over the past 21 days, possibly due to changes in metabolism associated with dementia. Will continue to monitor. There is no evidence of change in interventions for R100s weight loss. R100 suffered a severe weight losses on 8/20/18, 9/1/18 and 9/3/18. The facility failed to identify this weight loss, inform the registered dietician, and therefore no interventions were put into place to improve R100s nutritional status. These findings were reviewed with E1 (NHA) and E2 during exit conference on 9/6/18 at 2:00 PM.	F 692		

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F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide pain management care according to professional standard of practice for two (R105 and R42) out of 6 residents reviewed for pain management. R105 sustained harm when the facility continued to medicate R105 with an ineffective pain medication for approximately 15 hours before requesting a change in the medication order. Findings include: April 2002 - The pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. 2012 - FDA recommendation of maximum acetaminophen (Tylenol) dosage to prevent liver damage: a maximum daily dose for adults of 3 grams, with no more than 650 mg every 6 hours, as needed. Cross refer F580	F 697	#1 1. No corrective action can be taken for R105 as she had expired prior to the survey on 4-18-18. 2. All residents experiencing pain have the potential to be impacted by a failure to provide effective pain management. 3. The pain management for this resident was determined to be deficient based on the facilities failure to properly assess, provide interventions to manage pain, and re-assess for effectiveness of interventions. Medication provided to this resident was noted to be greater than the recommended dose allotment. Per review, it was determined that the education was needed for licensed nursing staff related to assessing for verbal and non-verbal signs of pain, initiation of pharmacological and non-pharmacological measures for pain management; pre and post intervention assessment for effectiveness, and notification of the Practitioner of ineffective pain management. Also noted was a knowledge deficient related to the FDA recommendations for the maximum daily dosage for Acetaminophen. The Staff Educator/ designee will provide	11/26/18

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F 697	Continued From page 61 1. Review of R105's clinical record and facility documents revealed: 4/5/18 Facility Event Report (closed 4/13/18): - E2 (DON) wrote: R105 was admitted to Renaissance on 4/15/15 for long-term care. On 1/22/18 she was transferred to our Dementia unit related to her marked increase in confusion related to her Dementia. She recently had Hospice services added after her decline. On 4/5/18 during the 11 PM -7 AM shift, she verbalized discomfort to her right hip. Interventions: She was assessed by the nurse and medicated. She was assessed by the Nurse Practitioner and an order for an x-ray was received. Her x-ray showed a broken right hip. Her family did not want her to have any further testing or procedures completed related to her continued decline. She is receiving analgesic for her discomfort. "Unknown etiology of fracture. ? Osteopenia (bone loss). ? Fall..." - E32 (RN Supervisor) wrote: On 4/4/18 R105 was seen self-propelling in hallway. Last rounds approximately 9:30 PM resident showed no signs of pain. - E30 (CNA) wrote: I worked 3:00 PM to 7:00 AM on 4/4/18 into 4/5/18. I did not have R105 on the 3:00 PM to 11:00 PM portion of my shift. I did rounds on her at 11:30 PM, and noticed her laying facing the window. When I changed her she began to roll to her back and she began to yell out in pain. I asked her what hurt. She was holding her right hip. I went and told the nurse. Everytime I changed her she complained about pain. I have patient on 11:00 PM - 7:00 AM often; she always complains about some general discomfort, but last night was different. -E31 (LPN) wrote: On 4/5/18 approximately 4:00 AM called to (R105's) room due to resident	F 697	training for licensed nurses regarding pain management and recommended dosing for Acetaminophen. The licensed nurses will demonstrate competence (testing) in understanding principles of pain management and administration of acetaminophen per recommended guidelines 4. DON/Designee will audit residents receiving routine and / or as needed pain medication to determine the effectiveness of the interventions based upon verbal or behavioral pre-pain assessment and post-pain assessments in relationship to the resident□s acceptable level of pain. Five residents per nursing unit will be audited on a daily basis until 100% compliance is achieved for a one week period. Then random audits will continue to be performed for 5 residents per nursing unit every other week until 100% compliance is reached for 3 consecutive weeks. Random audits will then be performed once a month x 2 consecutive months to determine compliance with pain management. Once achieved the deficient practice will be considered resolved. Audits will be reviewed during the facility□s Quality Assurance Performance Improvement meetings. #2 1. The pain management regimen for this R42 was reviewed by the Practitioner. Her current orders in the Electronic health record will document her acceptable level of pain, her every shift pain assessment, and pre-pain/ post-pain medication administration effectiveness as it relates	

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F 697	Continued From page 62 continue to complain about pain to right hip. Upon assessment resident refused to move right leg and continue to state 'I can't, it hurt.' No discoloration noticed. Only resident favoring right leg and refused to lay anyway but on her left side with her knees bent almost in fetal position. E31 gave resident PRN acetaminophen, which was not effective. She received routine acetaminophen, which was not effective. Staff reported resident continued in pain to right side. Approximately 6:30 AM resident received PRN Ibuprofen. E31 documented and charted in the Doctor Book to have resident assessed and report it to next shift nursing staff. 4/5/18 at 4:23 AM - Review of eMAR: E31 (LPN) administered 1,000 mg of acetaminophen. Pre (before) and post (after)pain scores were both 6, and documented not effective. 4/5/18 at 4:24 AM - Nursing Note: Resident received acetaminophen 650 mg due to complaint of pain to right hip during care. Resident has very little range of motion, refuses to move right leg due to complaint of pain. When resident was asked to move her leg she stated "I can't it hurt". Will continue to monitor. 4/5/18 at 6:00 AM - Review of eMAR: E31 (LPN) administered 650 mg of acetaminophen. Pre and post pain scores were both 6 (out of 10), indicating not effective. 4/5/18 at 6:35 AM - Review of eMAR: E31 (LPN) administered 400 mg of Ibuprofen. Pre pain score was 6 and post pain score was 2, and documented only slightly effective. 4/5/18 at 6:58 AM - Nursing Note: Resident continued to complain of pain to right hip. Resident received Ibuprofen 400 mg; awaiting results at this time. Resident is laying on side. Will continue to monitor. 4/5/18 at 8:45 AM - Nursing Note: Resident lying	F 697	to her acceptable level of pain. 2. All residents have the potential for not being assessed for acceptable levels of pain and effectiveness of pain management. 3. A root-cause analysis revealed that the cause of this deficient practice was related to an improper order entry into the Electronic Health Record. A full facility audit was conducted to determine if other residents were affected by this practice. The facility will provide re-education for licensed nurses related to the order entry in the Electronic Medication Administration Record (EMAR) for: acceptable levels of pain (verbal or non-verbal/ behavioral); pain assessments documentation every shift and pre/ post pain assessments after as needed (PRN) pain medication administration. The licensed nurses will show competency in this process through return demonstration of order entries. 4. The Unit Managers/ designee will audit order entries for: acceptable levels of pain (verbal or non-verbal/ behavioral); pain assessments documentation every shift and pre/ post pain assessments after as needed (PRN) pain medication administration, for five residents per nursing unit on a daily basis until 100% compliance is achieved for a one week period. Then random audits will continue to be performed for 5 residents per nursing unit every other week until 100% compliance is reached for 3 consecutive weeks. Random audits will then be performed once a month x 2 consecutive months to determine compliance with pain management. Once achieved the	

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F 697	Continued From page 63 in bed this morning complaining of pain all over, unable to straighten right leg. Resident has no redness swelling, discolorations, Notified Nurse Practitioner who came to assess and ordered a STAT right hip X-ray. Resident given Ibuprofen at 6:30 AM this morning. Hospice nurse in to see patient, will follow up with them with results. 4/5/18 at 2:00 PM - Review of eMAR: E37 (RN) administered 650 mg of acetaminophen. Pre and post pain scores were both 7, indicating not effective. 4/5/18 at 2:44 PM - Nursing Note: Resident has remained on bed rest today. Incontinent of urine; skin care done. During skin care she complained of pain when repositioned. Acetaminophen given for pain with no positive results. Daughter remained at bedside. 4/5/18 at 3:00 PM - Nursing Note: Resident's x-ray results received and reviewed by Nurse Practitioner. Resident had acute fracture of the right hip. Resident daughter met with Nurse Practitioner. She discussed with her the results and treatment options. Daughter does not wish for patient to be sent to hospital at this time for evaluation; she would like her kept here and made comfortable. Morphine 5 mg every 4 hours ordered routinely, daughter agrees with new order at this time. 4/5/18 at 3:45 PM - Nursing Note: Morphine given to patient; she is resting in bed at this time. 4/5/18 at 9:41 PM - Nursing Note: Resident on bed rest for fracture, Morphine was given routinely. Resident complained of pain and discomfort when turned for care. Resident restless in bed. 4/6/18 at 1:25 AM - Nursing Note: Resident continues to be restless and have pain and discomfort, resident continued to favor right hip, resident received morphine 0.25 mL, resident	F 697	deficient practice will be considered resolved. Audits will be reviewed during the facility□s Quality Assurance Performance Improvement meetings.	

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F 697	Continued From page 64 received Ativan 0.5 mg tab by mouth due to continued attempts to exit bed. 4/6/18 at 3:13 PM - Nursing Note: Resting in bed comfortably slight grimacing with care. Morphine given as per MD order. Daughter at bedside this afternoon.. 4/6/18 at 11:11 PM - Nursing Note: Resident remained in bed on this shift, gave Morphine routinely every 4 hours and monitored closely. Resident complained of pain and discomfort when doing care . 4/6/18 at 11:23 PM - Review of eMAR: E31 administered 1,000 mg of acetaminophen. Pre pain score was 8 and post pain score was 4, and documented only slightly effected. 4/7/18 at 4:42 AM - Nursing Note: Resident continue to complain of, and show signs of, pain and discomfort related to right hip fracture. Will continue to monitor. 4/7/18 at 7:07 AM - Nursing Note: Resident received Ibuprofen 400 mg due to complaint of and signs of pain and discomfort, and Ativan 0.5 mg due to increase anxiety; awaiting results at this time. 4/7/18 at 7:39 AM - Nursing Note: Some signs of discomfort Gave Morphine, effective; rested comfortably most of shift. 4/7/18 at 4:39 PM - Nursing Note: Assessed resident while giving routine medications. Resident grimacing, and visibly shaking. I sat resident up to give her the medications and resident cried out in pain and grabbed her hip. Reported excess pain and hospice recommendations to supervisor. 4/7/18 at 5:20 PM - Nursing Note: After medications given resident was resting comfortably, received scheduled Morphine at 4:00 PM as well as PRN Ativan. Resident is currently resting in bed, lowest position, appears	F 697		

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F 697	Continued From page 65 comfortable. 9/5/18 at 10:45 AM - Interview with E2 (DON) reviewed that R105 was initially only medicated with Acetaminophen and Ibuprofen which was ineffective in managing her pain. The facility failed to analyze the information from the pain assessments and failed to notify the physician for a new medication order. 9/6/18 at 4:30 PM - Interview with R105's daughter and emergency contact confirmed that resident was in severe pain during the night shift and day shift on 4/5/18 and that R105 was not comfortable for several days after the fractured hip was discovered on 4/5/18. Additionally references listed above in nursing notes state that the resident stated her right hip hurt, refused to move her right leg due to pain and was unable to straighten her right leg. Despite the fact that R105 had increased pain first identified at 11:30 PM on 4/4/18 she only received Acetaminophen and Ibuprofen, until 4/5/18 at 3:45 PM when the first dose of routine every 4 hour Morphine was ordered and given. However, the Acetaminophen, Ibuprofen and Morphine were ineffective in managing her pain for over 48 hours as evidenced by multiple episodes of severe pain documented in nursing notes. In addition, E31 documented R105 was given greater than recommended maximum acetaminophen dosage of no more than 650 mg every 6 hours. On 4/5/18, E105 was given 1,000 mg at 4:23 AM and 650 mg at 6:00 AM (less than 90 minutes apart). The facility failed to effectively manage the resident's pain resulting in an extended period of severe pain. 2. Review of R42's clinical record revealed: 3/29/18 - Admission MDS assessment included that R42 had severe cognitive impairment from	F 697		

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F 697	Continued From page 66 dementia with a BIMS of 3. 4/3/18 - Care plan for potential for pain related to surgery for broken bone included the interventions: administer non-pharmacological and pharmalogical pain interventions as ordered and report effectiveness to physician; assess for verbal and non-verbal pain indicators. March 2018 - August, 2018 - Review of eMARs and corresponding nursing progress notes found 6 out of 8 doses of PRN Tylenol without pain severity rating before and after the PRN medication to assess the effectiveness of the pain medication intervention. - April 2 (3:21 AM). - May 28 (6:04 AM). - Jun 29 (12:18 AM). - Aug 12 (8:50 AM), 17 (6:44 PM) and 24 (12:13 AM). The entry on the eMAR did not include the space to write the pain severity before and after administration. 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews. 9/6/18 (10:40 AM) - Interview with E4 (UM) to review the missing pain assessments. E4 stated the order was not entered into the computer accurately since it was missing the boxes to enter the pain assessments. E4 confirmed the non-verbal pain scale assessing resident behaviors could be used for R42.	F 697		

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F 697	Continued From page 67 This finding was reviewed with E1 and E2 during the exit conference on 9/6/18 at 2:00 PM.	F 697		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure one (R42) out of 5 sampled residents for medication review were seen by the provider timely. Findings include: State Operations Manual documented "Permitting up to 10 days' slippage of a due date will not affect the next due date". . . There is no provision for physicians to use discretion in visiting at intervals longer than those specified.	F 712	1. R42 was not negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. The facility will take the following corrective actions as outlined in #3 below. 3. The Medical Record personnel will utilize a spreadsheet to document Physician and Practitioner visits to each resident per regulatory guidelines. The Medical Record personnel will alert the	11/26/18

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F 712	Continued From page 68 Review of R42's clinical revealed: 3/22/18 - Admission to facility. March 2018 - August 2018 - Review of physician and NP visits found R42 had a history and physical on 3/22 and was seen 4/16/18 but was not seen every 30 days for the first 90 days by the provider and was not seen: - May, 2018 (no visit): was due 5/21 by MD. - 6/7/18 (NP): was due 6/20. 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews including the timeliness of provider visits. This finding was reviewed with E1 and E2 during exit conference on 9/6/18 at 2:00 PM.	F 712	Nursing Home Administrator (NHA) and the Medical Director of physician compliance issues. It will be the responsible of the NHA and the Medical Director to address non-compliance issues with the physician and determine additional measures to be taken. 4. The Medical Record personnel will provide the NHA and the Medical Director with the Physician / Practitioner Visit Spreadsheet on a weekly basis. The NHA will audit the physician visits as per regulatory guidelines weekly x 4 week or 100% compliance is noted, followed by monthly audits x 4 until 100% compliance is noted. The results of the audits will be provided to the Medical Director and will be reviewed in Quality Assurance Performance Improvement meeting.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of other facility documentation it was determined that the facility failed to ensure consistent caregivers for three (R31, R42 and R54) out of 3 sampled residents for review of dementia care.	F 744	#1 1. There was no evidence that R31 was negatively impacted by this deficient practice. 2. All residents on the dementia unit have the potential to be impacted by a lack of	11/26/18

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F 744	Continued From page 69 Findings include: 1. Review of R 31's clinical record revealed: 2/24/11 - Admission to facility. 10/22/14 - Care plan for cognitive loss / dementia included the intervention to provide consistent caregivers. 6/19/18 - Annual MDS Assessment documented R31 had dementia with moderate cognitive impaired and no aggressive / resistive behaviors. 8/27/18 - 8/31/18 and 9/4/18 - 9/6/18 - Observation throughout the survey and review of staffing sheets provided daily by the facility revealed the secured (Bethany) unit was staffed with a different nurse on day and evening shift for 6 out of the 7 days of the survey. 9/6/18 (10:45 AM) - Interview with E4 (UM) revealed the UM was covering two separate units until a new UM could be hired. E4 added that many of the nurses changed units and many "PRN and part-timers" had been assigned to work on the secured unit. The UM indicated that nurses on that unit will be working 12 hour shifts in the future. 2. Review of R42's clinical record revealed 3/22/18 - Admission to facility. 3/29/18 Admission MDS Assessment documented R42 had dementia and severe cognitive impairment. The resident experienced physical aggression 4 to 6 days during the assessment week.	F 744	consistency of management staff. However, all nursing staff members receive training related to dementia care practices, the Certified Nurse Aides (C.N.A.s) who served as direct caregivers were consistently assigned to the Unit and the facility has completed the hiring and assignment of a permanent Unit Manager for the dementia unit. 3. At the time of the survey the facility was in the process of hiring and training a new Unit Manager for this Unit. The Unit Manager is now in her position. The Unit Manager will be responsible for the oversight of the Nurses and C.N.A. assignments to promote consistency (as staffing permits). Licensed nursing schedules have transitioned from 8 hour shifts to 12 hour shifts. 4. The Facility Nursing Scheduler will perform random audits for consistency of staffing on the dementia unit. The Nursing Deployment Sheets/ Assignment Sheets will be audited on a daily basis for 2 consecutive weeks or until the audit shows consistency of staff members assigned to this unit during this 2 week period. Once this compliance is achieved, the audit will be conducted twice a month for a 3 consecutive day period to determine compliance with consistent staffing. This audit will be followed by a once a month 3 consecutive day audit x 2 consecutive month. Determination of compliance will result in resolution of the deficient practice as evidence by consistent staffing patterns. All audits will be reviewed in the facility Quality Assurance Performance Improvement	

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F 744	Continued From page 70 4/3/18 - Care plan for cognitive loss / dementia included the intervention to provide consistent caregivers when possible. 4/26/18 - Transferred to the secured unit due to exit seeking. 6/28/18 - Quarterly MDS Assessment documented no changes to R42's cognitive impairment or physical aggression. 8/27/18 - 8/31/18 and 9/4/18 - 9/6/18 - Observation throughout the survey and review of staffing sheets provided daily by the facility revealed the secured (Bethany) unit was staffed with a different nurse on day and evening shift for 6 out of the 7 days of the survey. 9/6/18 (10:45 AM) - Interview with E4 (UM) revealed the UM was covering two separate units until a new UM could be hired. E4 added that many of the nurses changed units and many "PRN and part-timers" had been assigned to work on the secured unit. The UM indicated that nurses on that unit will be working 12 hour shifts in the future. 3. Review of R54's clinical record revealed: 6/11/15 - Care plan for cognitive loss / dementia (last revised 7/16/18) included the intervention to provide consistent caregivers when possible. 4/6/18 - Quarterly MDS Assessment documented R54 had moderate cognitive impairment with physical and verbal aggression 1-3 days during the assessment week.	F 744	meeting. #2 1. There was no evidence that R42 was negatively impacted by this deficient practice. 2. All residents on the dementia unit have the potential to be impacted by a lack of consistency of management staff. However, all nursing staff members receive training related to dementia care practices, the Certified Nurse Aides (C.N.A.s) who served as direct caregivers were consistently assigned to the Unit and the facility has completed the hiring and assignment of a permanent Unit Manager for the dementia unit. 3. At the time of the survey the facility was in the process of hiring and training a new Unit Manager for this Unit. The Unit Manager is now in her position. The Unit Manager will be responsible for the oversight of the Nurses and C.N.A. assignments to promote consistency (as staffing permits). Licensed nursing schedules have transitioned from 8 hour shifts to 12 hour shifts. 4. The Facility Nursing Scheduler will perform random audits for consistency of staffing on the dementia unit. The Nursing Deployment Sheets/ Assignment Sheets will be audited on a daily basis for 2 consecutive weeks or until the audit shows consistency of staff members assigned to this unit during this 2 week period. Once this compliance is achieved, the audit will be conducted twice a month for a 3 consecutive day period to	

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F 744	Continued From page 71 7/6/18 - Annual MDS Assessment documented the resident's cognitive impairment progressed to severe and had no behaviors during the week of the assessment period. 8/27/18 - 8/31/18 and 9/4/18 - 9/6/18 - Observation throughout the survey and review of staffing sheets provided daily by the facility revealed the secured (Bethany) unit was staffed with a different nurse on day and evening shift for 6 out of the 7 days of the survey. 9/6/18 (10:45 AM) - Interview with E4 (UM) revealed the UM was covering two separate units until a new UM could be hired. E4 added that many of the nurses changed units and many "PRN and part-timers" had been assigned to work on the secured unit. The UM indicated that nurses on that unit will be working 12 hour shifts in the future. These findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 9/6/18 at 2:00 PM.	F 744	determine compliance with consistent staffing. This audit will be followed by a once a month 3 consecutive day audit x 2 consecutive month. Determination of compliance will result in resolution of the deficient practice as evidence by consistent staffing patterns. All audits will be reviewed in the facility Quality Assurance Performance Improvement meeting. #3 1. There was no evidence that R54 was negatively impacted by this deficient practice. 2. All residents on the dementia unit have the potential to be impacted by a lack of consistency of management staff. However, all nursing staff members receive training related to dementia care practices, the Certified Nurse Aides (C.N.A.s) who served as direct caregivers were consistently assigned to the Unit and the facility has completed the hiring and assignment of a permanent Unit Manager for the dementia unit. 3. At the time of the survey the facility was in the process of hiring and training a new Unit Manager for this Unit. The Unit Manager is now in her position. The Unit Manager will be responsible for the oversight of the Nurses and C.N.A. assignments to promote consistency (as staffing permits). Licensed nursing schedules have transitioned from 8 hour shifts to 12 hour shifts. 4. The Facility Nursing Scheduler will perform random audits for consistency of	

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F 744	Continued From page 72	F 744	staffing on the dementia unit. The Nursing Deployment Sheets/ Assignment Sheets will be audited on a daily basis for 2 consecutive weeks or until the audit shows consistency of staff members assigned to this unit during this 2 week period. Once this compliance is achieved, the audit will be conducted twice a month for a 3 consecutive day period to determine compliance with consistent staffing. This audit will be followed by a once a month 3 consecutive day audit x 2 consecutive month. Determination of compliance will result in resolution of the deficient practice as evidence by consistent staffing patterns. All audits will be reviewed in the facility Quality Assurance Performance Improvement meeting.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		11/26/18

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F 757	Continued From page 73 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to monitor the effects of blood pressure medication and identify a low blood pressure for one (R42) out of 5 residents sampled for medication review. Findings include: Review of R42's clinical record revealed: 3/22/18 - Admitted to the facility after surgery for a broken thigh bone. Admission orders included a medication for high blood pressure to be given once a day and to assess vital signs every shift while receiving physical therapy. 3/29/18 - Admission MDS assessment documented R42 had dementia and was severely cognitively impaired with a BIMS of 3. 4/26/18 - Transferred from long term care unit (Fenwick) to the secured unit (Bethany). March 2018 - August, 2018 - Review of blood pressures within the vital signs section and nursing progress notes found: - 3/22/18 - 4/25/18: BP ranged from 106/67 to 145/79. - No blood pressures between 4/26/18 - 6/1/18, 6/3/18 - 6/15/18 and 6/29/18 - 8/23/18. - June 26 (6:28 AM): BP low at 92/55 without evidence of repeating for accuracy nor notification	F 757	1. R42 was not negatively impacted by this deficient practice. R42 blood pressure will be monitored on a weekly basis per physician order. 2. Residents who are receiving medications to control hypertension have the potential to be impacted by lack of blood pressure monitoring. The need for monitoring is a physician□s judgement and may vary per the individual□s medication regimen and stability of their condition. Based upon physician and/ or pharmacist recommendations resident□s receiving anti-hypertensive medications may be ordered blood pressure monitoring. 3. Residents receiving antihypertensive medications will be reviewed by their physician/ practitioner to determine the need of blood pressure monitoring as well as the frequency of monitoring and any associated parameters. The pharmacist will review the resident□s anti-hypertensive medication(s) and make recommendations to the physician based on their review. The pharmacist will continue this process as part of their Monthly Medication Regimen Review. Licensed nurses will follow the physician□s orders related to monitoring. 4. Audits will be conducted based on	

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F 757	Continued From page 74 of the prescriber. 6/7/18 - Weekly utilization review note documented the last day of physical therapy services would be 7/3/18. 8/23/18 - Physicians' orders included obtain BP once a week for 6 weeks. 8/30/18 (untimed) - Interview with E2 (DON) during the survey to discuss frequency of vital signs. E2 stated the facility had no policy for the frequency of BP assessment if not ordered by the provider. 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews. E2 indicated the desire to review nursing notes to determine if any blood pressures were recorded there. 9/6/18 - The facility provided no further information regarding blood pressures. This findings was reviewed with E1 and E2 at the exit conference on 9/6/18 at 2:00 PM.	F 757	anti-hypertensive medication orders and orders for monitoring per physician orders and/ or pharmacist recommendations. The ADON/ designee will conduct the random audit 3 times week or until100% compliance is reached for 3 consecutive weeks. Random audits will then continue at once a week for 3 consecutive weeks or until compliance is met. The deficient practice will be deemed resolved upon determination of compliance.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		11/26/18

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F 758	Continued From page 75 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 76 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to adequately monitor the antipsychotic medications for two (R31and R8) out of 5 residents sampled for medication review. The facility also failed to ensure PRN orders for psychotropic medications were limited to 14 days for one (R54) out of 5 sampled residents of medication review. Findings include: Facility policy entitled Psychoactive Medication (revised 4/7/17) included: - residents receiving psychotropic medications are assessed and monitored for side effects, adverse effects, and the onset of new or worsening of symptoms. - assessment findings are documented in the medical record and include behavioral monitoring. - psychotropic medication may be ordered PRN ONLY if the drug is intended to treat a condition that is documented in the medical record: PRN orders are generally limited to 14 days but can be extended. PRN orders beyond 14 days require the provider to evaluate the resident and document the appropriateness of the extension. 1. Review of R8's clinical record revealed: 10/13/16 Physicians' Orders - ativan/benadryl/haldol (haldol is an antipsychotic drug), for dementia with psychosis, 3 times a day. 10/30/17 - AIMS (Abnormal Involuntary Movement Scale (AIMS) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive	F 758	1.R8 AIMS test was completed on 8/31/18 and new orders for AIMS test quarterly. R8 was not negatively impacted by this deficient practice. 2.All residents on antipsychotic medications have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. The facility determined that licensed nurses required additional training related to antipsychotic medications. Education will be provided to licensed nurses related to common antipsychotic medications and how, when and why an AIMS assessment is conducted. The nurse will demonstrate their competency in recognizing common antipsychotic medications by the drug name, reasoning for the AIMs assessment and their ability to order and execute the AIMs assessment in the Electronic Health Record. 4. Unit Manager/Designee will perform random audits new admissions to ensure random audits of psychotropic medications are completed and ordered quarterly.Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	

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F 758	Continued From page 77 dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications) completed. 8/31/18 around 12:30 PM - Surveyor requested all recent AIMS assessments for R8 from E2 (DON). No documents or information was provided. 8/31/18 3:04 PM - AIMS completed. 8/31/18 Physicians Orders - AIMS test quarterly, on first Monday of January, April, July, October. No AIMS assessments were completed for 10 months, until surveyor requested copies. 2. Review of R42's clinical record revealed: 4/6/18 - Physicians' orders included an antipsychotic medication for dementia with behavioral disturbances - delusions. March, 2018 - August, 2018 - Review of AIMS testing discovered: - no evidence that the assessment was completed prior to start of the medication to obtain the resident's baseline and monitor for abnormal movements associated with this type of medication. - 5/25/18: AIMS assessment completed, 7 weeks after the medication was initiated. March 2018 - August, 2018 - Review of behavior and side effect monitoring found: - 3/22/18: other psychotropic medications (for anxiety and depression) began 3/22/18. - 5/25/18: antipsychotic medication monitoring began, 7 weeks after initiation of the drug.	F 758	#2 1. R42 AIMS test was completed on 10/2/18 and new orders for AIMS test quarterly. R42 was not negatively impacted by this deficient practice. 2. All residents on psychotropic medications have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. It was determined the facility failed to complete an AIMs on a resident while on an antipsychotic medication. A facility wide was sweep was conducted an no other residents were identified as missing an AIMs test. The staff educator/designee will educate licensed nursing staff on completing an AIMs Test related to common antipsychotic medications and how, when, and why an AIMs test is conducted. The nurse will demonstrate competence on understanding when to complete an AIMs test. 4. DON/Designee will perform random audits new admissions to ensure random audits of psychotropic medications are completed and ordered quarterly.Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.1.R42 AIMS test was completed on 10/2/18 and new orders for AIMS test	

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F 758	Continued From page 78 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews including the lack of monitoring for an antipsychotic. 3. Review of R54's clinical record revealed: 1/16/18 - Physicians' orders included a medication for anxiety that could be given once a day PRN. This medication required the attending physician or prescribing practitioner to assess if it's appropriate for the PRN order to be extended beyond 14 days. The prescriber should document their rationale in the resident's medical record and indicate the duration for the PRN order. 1/22/18 - Assessment by E27 (Psychiatric NP) - R54 received the PRN, and current regimen continued. [No duration documented.] 2/9/18 - Assessment by E27 to follow-up on the PRN medication found the medication had not been used since the January assessment. [The medication regimen was continued with no duration.] 2/23/18 - Evaluation of the PRN medication due 14 days after prior evaluation, but not completed. 3/5/18 - Quarterly Psychotropic Reduction Meeting identified that R54 was prescribed the PRN medication for anxiety and continued the current medications. [No duration documented.]	F 758	quarterly. R42 was not negatively impacted by this deficient practice. 2.All residents on psychotropic medications have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. Staff educator will educate nursing staff on completing AIMS assessments on all new orders for psychotropics and quarterly. 4. DON/Designee will perform random audits new admissions to ensure random audits of psychotropic medications are completed and ordered quarterly.Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved. #3 1.R54 order for ativan was discontinued on 4/17/18. R54 was not negatively impacted by this deficient practice. 2.All residents on psychotropic medications have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. The Medical Director will re-educate facility providers regarding guidelines for prescribing PRN psychotropic	

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	085052	A. BUILDING _____ B. WING _____	C 09/06/2018

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F 758	Continued From page 79 4/17/18- Assessment by E27 discontinued the PRN medication for anxiety due to non-use. The facility failed to assess the need for the PRN medication for anxiety timely and indicate the duration for the continuation of the PRN psychotropic medication for anxiety. 9/5/18 (4:20 PM) - Interview with E1 (NHA), E2 (DON) and E12 (Corporate Nurse) to verbally discuss findings and provide written documentation of issues discovered from medication reviews including assessments for PRN medication for anxiety. These findings were reviewed with E1 and E2 at the exit conference on 9/6/18 at 2:00 PM.	F 758	medications can only be ordered for 14 days unless reassessment is completed. A facility wide sweep was conducted and no other residents were affected by this deficient practice. 4. DON/Designee will perform random audits to ensure MD/NP assessments are completed after 14 days or medication is discontinued. Random audits of psychotropic medications assessments will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 773	1.R23 was not negatively impacted by	11/26/18

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F 773	Continued From page 80 determined that for one (R23) out of 45 residents the facility failed to ensure laboratory results were obtained and provided to the ordering provider timely. For R23 the facility failed to treat a UTI for 22 days after the test result was available. Findings include: 1. The following was reviewed in R23's clinical record: 5/19/18 - MD order for urine culture, urinalysis and "call on call NP / MD with results". 5/19/18 - Urine collected for ordered urinalysis and culture with sensitivity. 5/21/18 - Urinalysis report from collection 5/19/18 signed by NP on 5/21/18 documenting "awaiting C&S". 5/23/18 - Urine culture final report indicating a UTI with the organism ecoli. The NP signed the lab slip on 6/13/18 and documented "[name of antibiotic] 100 mg x 5 days". 9/5/18 at 11:52 AM - Interview with E7 (NP) about the delay in the urine culture being addressed it was revealed that the facility had to call the lab to get the report, which was unusual for this lab. Typically it took about 3 days to get a urine culture. No additional explanation was offered about the delay. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 773	this deficient practice. 2.All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. The facility Unit Managers/Supervisors will begin tracking all ordered Urine results on the tracking tool to assure results have been received and that the Physician has been made aware of the results. The facility failed to obtain results for a urinalysis result for one resident. No other residents were identified to have been affected by this deficient practice. 4. DON/Designee will perform random auudits on securing timely lab results. Three random resident audits will be performed daily or until 100% compliance is reached for 3 consecutive days. Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5)	F 790		11/26/18

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F 790	Continued From page 81 §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 790		

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F 790	Continued From page 82 led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R23) out of 45 sampled residents the facility failed to failed to identify a dental potential dental need and failed to determine if a newly admitted resident wanted routine dental services. Findings include: The following was reviewed in R23's clinical record: 3/7/18 - admitted to the facility. 3/7/18 - Admission Assessment (nursing)- some missing teeth. 3/14/18 - Admission MDS documented no dental issues. 4/17/18 - MD order for dental consult as needed. 6/13/18 - Quarterly MDS documented no dental issues. 7/5/18 - (Re) Admission Assessment (nursing) - no dental issues, no dentures. 8/27/18 1:47 PM - Interview with R23 revealed that he has a partial denture, has not been to dentist since he was admitted and he did not think he had money / insurance to pay for the dentist. He stated he would see a dentist if he could and if he had the money. 8/29/18 12:13 PM - Interview with E3 (ADON) and E4 (UM) revealed the social worker was responsible for assessing whether the resident	F 790	1.R23 was not negatively impacted by this deficient practice. 2.All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. It was determined the nursing staff and social services failed to follow the Facility Dental Services Available to Residents policy. Staff educator will provide re-education on identifying residents regarding routine and emergent measures to follow for resident dental needs. 4. RNAC/Designee will perform random audits to ensure dental needs/services are addressed timely. Three random resident audits will be performed daily or until 100% compliance is reached for 3 consecutive days. Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	

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F 790	Continued From page 83 wants dental services and arranging for them either in house or from outside providers. The discrepancies in dental assessments were reviewed. E4 asked E24 (CNA) about R23's teeth. E24 responded that the resident has partial dentures but they don't fit possibly from the resident's mouth getting smaller. The social worker was contacted to see if R23 was placed on the list to see the dentist. 8/29/18 1:04 PM - Follow-up interview with E4 revealed that the resident was out at the hospital when the dental service was in the facility and the dentist was due to come in this Friday and the resident was added to the list to be seen. The facility has been unable to provide evidence that R23 was previously referred to the dentist. 8/29/18 2:56 PM - Interview with E4 revealed a call had been made to the family to see if they would authorize payment for the dental visit on Friday. Also stated that R23 was not on the July dental list. It was revealed that residents are asked verbally during admission if they want to receive dental services. There was no evidence that this was done for R23. 8/29/18 3:07 PM - Interview with R23's family contact person revealed that s/he has never been asked about dental services and that s/he was unaware of any issues with the dentures. it was confirmed that the resident is private pay and there were funds to pay for dental services. The facility failed to conduct an accurate dental assessment when they did not identify R23 had partial dentures and had issues with the fit. R23 was not assessed for routine dental services on admission or during the first 5 months since	F 790		

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F 790	Continued From page 84 admission. These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 790		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of facility submitted documents and interview, it was determined that the facility failed to maintain documentation, and demonstrate evidence of, an ongoing QAPI (Quality Assurance and Performance Improvement) program that meets the requirements implemented on November 28, 2017 when the facility presented to the SA (State Agency) a QAPI plan that used obsolete references for the purpose of identifying area's of	F 865	1.No resident was negatively impacted by this deficient practice. 2.No residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. On 9/5/18 deficiency was corrected in the QAPI program. 4. The obsolete reference to Qis was	11/26/18

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F 865	Continued From page 85 concern and defining and measuring goals. Findings include: 9/5/18 - Review of the facility submitted QAPI Plan dated 10/20/16 and reviewed on 8/27/18, 7/11/18, by E11 (corporate compliance nurse) contained the following content: - Defining and Measuring goals: The sampling, assessment, and data collection tools are based on the CMS (Center for Medicare &Medicaid Services) QIS (Quality Indicator Survey)process and the QCLI's (Quality of Care and Life Indicators) to identify potential area's of concern. - The QA&A committee will review and submit proposed revisions to the governing body for approval on an annual and/or as needed basis. During an interview on 9/5/18 at 1:55 PM with E11, it was confirmed that the QAPI plan submitted to the SA contained references to QIS (Quality Indicator Survey) process and the use of QCLI's (Quality of Care and Life Indicators), both of which are no longer in use as of November 2017, to identify potential areas of concern. E11 further explained that the QAPI plan was "updated constantly", and the QIS references "got missed in the update." These findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 9/6/18 at 2:00 PM.	F 865	removed from the QAPI Program.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		11/26/18

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F 880	Continued From page 86 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 87 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was discovered that the facility failed to ensure infection control practices were followed. Findings include: 8/30/18 (9:05 AM - 9:15 PM) - Observation without appropriate hand hygiene. - E28 (Maintenance) cleaning a mattress leaning on a wheeled cart by the nursing station on Rehoboth unit using wipes and not wearing gloves. - After throwing out the used wipes, did not perform hand hygiene, then pushed the wheeled cart containing the mattress off the unit.	F 880	1.No resident was negatively impacted by this deficient practice. 2.All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in #3 below. 3. Staff Educator will re-educate maintenance department on infection control policy on handwashing. 4. Staff educator/Designee will perform random audits on three random staff members daily for three days or until 100% compliance is reached for 3	

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F 880	Continued From page 88 - While going through Fenwick unit, E28 used his contaminated hands and pushed a food cart out of the hallway using the handle on the side of the cart. - E28 proceeded to the storage room and punched in the code on the door lock and opened the door. - After placing the mattress into the storage room and closing the door, E28 pushed the empty cart and placed in the storage hallway. - E28 walked to Rehoboth unit and E29 (LPN) opened the medication preparation room and unlocked the refrigerator, the medication room door closed causing E28 to not be visible. - At 9:15 PM E28 left the med room, interview with E29 determined that E28 measured something in the refrigerator. 8/30/18 (approximately 11:40 AM) - Interview with E1 (NHA) to discuss the aforementioned observation. 8/30/18 (approximately 2:00 PM) - Interview with E10 (Facility Maintenance Director) regarding the morning observation, E10 said s/he "knows better." This finding was reviewed with E1 and E2 (DON) during the exit conference on 9/6/18 at 2:00 PM.	F 880	consecutive days. Random audits will then be performed 3 times weekly or until 100% compliant is reached for 3 consecutive times. Random audits will continue at 1 time a week for 3 consecutive weeks or until 100% compliant. If a random sample of 3 resident audits are 100% compliant in 1 month the deficiency will be considered resolved.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19808
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Renaissance

DATE SURVEY COMPLETED: September 6, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from August 27, 2018 through September 6, 2018. The facility census the first day of the survey was 106 (one hundred six). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies		
3201	based on observation and interviews.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross Refer to the CMS 2567-L survey completed September 6, 2018: F550, F553, F580, F583, F641, F656, F657, F684, F686, F689, F690, F692, F697, F712, F744, F757, F758, F773, F790, F856, and F880.	Cross refer to the plan of correction for CMS 2567-L survey completed Sept. 6, 2018: F550,F553,F580,F583,F641, F656,F657,F684,F686,F689, F690,F692,F697,F712,F744, F757,F758,F773,F790,F856, F880	

Provider's Signature Joyce Winters Title Administrator Date 10/5/18